

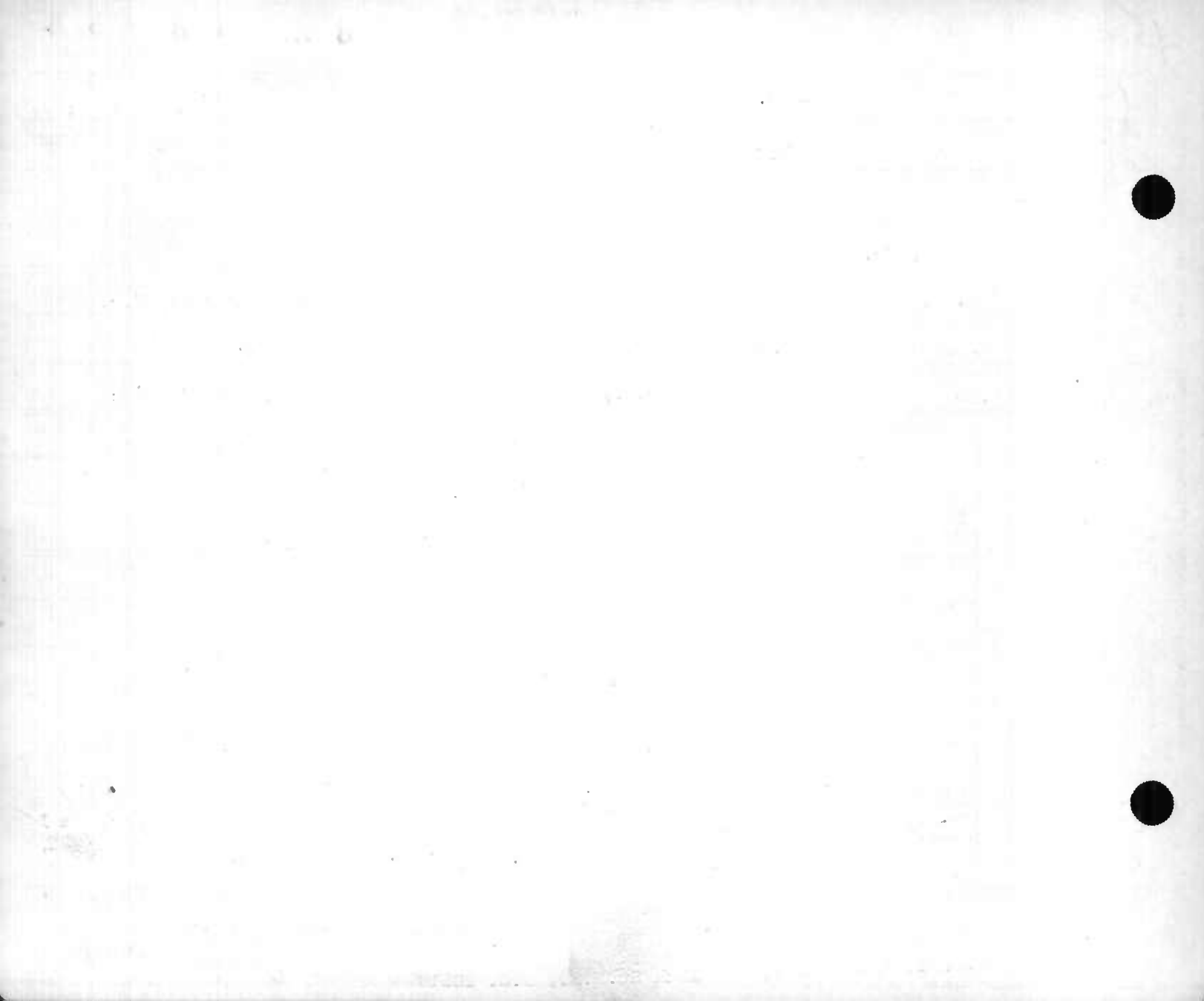
15-2

Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1- FOR STATE REGISTRAR										
REG. NO. 8 2 1 8 9 6 8										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE L. ANDERSON					2a. DATE OF DEATH MONTH DAY YEAR July 29, 1982		2b. HOUR 10:45AM			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR May 29, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH P.G.				
10. CITY OR TOWN OF DEATH Clinton, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9108 Townsend Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY None		
13a. STATE D. C.					13b. COUNTY Washington		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 606 Irving Street, N.W.	
14. FATHER'S NAME FIRST MIDDLE LAST George Anderson, Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Randolph					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. 577-01-4912		17. INFORMANT ADDRESS Mrs. Gladys N. Anderson/wife/same as			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 13e 4379 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Vascular Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years " "										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (1) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (1) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22a. SIGNATURE Lawell H Weiss MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/30/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawell H Weiss					22e. ADDRESS 730 24th St NW Wash DC 20037					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-2-82		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Md.				
24. FUNERAL DIRECTOR NAME John T. Rhines Co., 3015 12th St N.E., D.C. 20017					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 10 1982 [Signature]					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 18969			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) <b>HENRY A. ARRINGTON</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>7 9 1982</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3-1-1926</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>56 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bowie.</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BOWIE HEALTH CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Plumber</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>PRINCE GEORGE</b>		13c. CITY OR TOWN <b>LOTHIAN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>681 WEST BAYFRONT ROAD</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>ALBERT ARRINGTON</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MINNIE TAYLOR</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT ADDRESS <b>MRS. ELAINE ARRINGTON (SAME AS #13 ABOVE)</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100 Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASVD hx of myocardial</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>infarction</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>SAM A. DARR MD</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER				DATE SIGNED <b>7-10-82</b>	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>7/13/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MD. V.A. CEMETERY</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>CHELTENHAM, PR. GEO. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>TAKOMA FUNERAL HOME</b>				ADDRESS <b>254 CARROLL ST. NW WASHINGTON, D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 13 1982</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

ALBERT TAYLOR  
214-24-2415 FRAINE HARRINGTON  
(Spouse of Albert Taylor)  
MINNIE HARRINGTON  
214-24-2415 FRAINE HARRINGTON  
(Spouse of Albert Taylor)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 8 9 7 0		
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH								REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) <b>ELIZABETH Jane ATCHISON</b>					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR <b>07 01 82 12:01A.M.</b>							
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Nov. 7, 1885</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>96</b>		IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		IF UNDER 72 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges MD.</b>						
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital Center</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. STATE <b>Md.</b>					13b. COUNTY <b>Prince Geo.</b>		13c. CITY OR TOWN <b>Brandywine</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 2, Box 207*A.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Doc Pickeral</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unavailable</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>231-70-6699</b>		17 INFORMANT ADDRESS <b>Mary Hazel Penn, Same as # 13</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic obstructive pulmonary disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Arteriosclerosis, Arterio-sclerotic cardiovascular disease, sepsis</b>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>6-25-1982</b> , to <b>7-1-82</b> , that (I) (we) lost saw the deceased alive on <b>6-30-1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Nemati</b>					DEGREE			22c. DATE SIGNED <b>7-1-82</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Nemati, M., M.D.</b>					22e. ADDRESS <b>3611 Branch Ave., Marlow Heights, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7-3-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waldorf, Chas. Md.</b>				
24 FUNERAL DIRECTOR NAME <b>Hunt Funeral Home, Waldorf, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUL 7 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Nathan</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 8 9 7 1	
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH								REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
JOSEPH				BACHMEIER				07-01-82		12:25AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 74 HRS.	
Male		White		Feb. 12, 1904		78		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Germany		USA				PRINCE GEORGE'S COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CHEVERLY		PRINCE GEORGE'S GENERAL HOSPITAL						Landscaper		U.S. Gov't.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.		PG		Capt. Hgts		YES <input type="checkbox"/> NO <input type="checkbox"/>		11 Akin Avenue			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
Karl				Bachmeier				Kundagunda ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (TYPE, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				577-30-7462		Same as Above Marie Bachmeier, Wife					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia - Probable</u>											
4340 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebro Vascular Thrombosis</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
-				-				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3-19</u> , 19 <u>82</u> , to <u>6-30</u> , 19 <u>82</u> that (I) (we) last saw the deceased alive on <u>6-30</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
<u>S. Gupta</u>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
SURESH C. GUPTA M.D.				3503 PERRY ST. MT. RAINIER MD. 20822							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				7-6-82		Resurrection Cem.		Clinton, P.G. Md.			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. DATE REC'D. BY REGISTRAR					
Robt E Wilhelm				4308 Suitland Rd., Suitland, Md.		6 1982					

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07-01-02 12:00

COMPTON

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PRINCE GEORGE'S COUNTY

POLICE DEPARTMENT'S OFFICE HOSPITAL

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10-10-02 12:00

10-10-02 12:00

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 1 8 9 7 2	
1. FOR STATE REGISTRAR										7a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) <b>Robert J. Bainer</b>										7b. DATE KNOWN OF DEATH <b>7 17 82</b>	
3. SEX <b>Male</b>										7c. DATE PRONOUNCED DEAD <b>7 17 82</b>	
4. RACE <b>White</b>										7d. HOUR <b>4 PM</b>	
5. DATE OF BIRTH <b>June 3, 1928</b>										7e. MONTH <b>7</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b>										7f. DAY <b>17</b>	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>										7g. YEAR <b>19 82</b>	
7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>										7h. HOUR <b>6 PM</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Cheverly</b>										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, STREET ADDRESS) <b>6413 Landover Road # 102</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver</b>										12b. KIND OF BUSINESS OR INDUSTRY <b>Purple Heart</b>	
13a. STATE <b>Maryland</b>										13b. COUNTY <b>P.G.</b>	
13c. CITY OR TOWN <b>Cheverly</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>6413 Landover Road # 102</b>										13f. COMPANY <b>Company</b>	
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Howard Bainer</b>										15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Alice Garrison</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes-Navy</b>										16b. SOCIAL SECURITY NO. <b>111-20-8561</b>	
16c. (IF YES, GIVE WAR OR DATES) <b>W.W.II &amp; Korea</b>										17. INFORMANT ADDRESS <b>Susan Lynn Parker Court # 2 -Laurel, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEIZURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma of Larynx</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21c. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Said A. Dace, M.D.</b> M.D. <b>Deputy</b> MEDICAL EXAMINER										DATE SIGNED <b>7-17-82</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Said A. Dace, M.D.</b>										ADDRESS <b>5632 Annapolis Rd. Suite #4-Bladensburg</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>										23b. DATE <b>July 19, 1982</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>										23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>										25a. DATE REC'D. BY REGISTRAR <b>JUL 20 1982</b>	
25b. REGISTRAR SIGNATURE <b>[Signature]</b>											

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 8 9 7 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Margaret R. Baker</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>07 22 82</b>			2b. HOUR <b>11:15P.M.</b>					
3. SEX <b>Female</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 14 1932</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>49</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD.					
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Ft. Wash.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>9320 Lancelot Rd.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frederick E. Branson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lula Haynes</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>none</b>			17. INFORMANT ADDRESS <b>Harry Baker same as item 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> 2840 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aplastic Anemia</b> 1 year DUE TO, OR AS A CONSEQUENCE OF (c) <b>Breast Cancer</b> 8 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>none</b>											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>22 July 82</b> to <b>22 July 82</b> , then (I) (we) lost saw the deceased alive on <b>22 July 82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <b>Rene Grace</b> DEGREE			22c. DATE SIGNED <b>23 July 82</b>					22d. ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rene Grace, MD</b>			22f. ADDRESS <b>9131 Piscataway Rd. Clinton Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7/26/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clinton P.G. Md.</b>				
24. FUNERAL DIRECTOR NAME <b>G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUL 27 1982</b>					25b. REGISTRAR'S SIGNATURE <b>James Santhos</b>	

C. E. Kates 6160 Oxon Hill Rd. Oxon Hill, Md.

Resurrection Cemetery Clinton P.O. Md.

Rene Grace, MD 9131 Pleasantway Rd. Clinton Md.

*Handwritten notes and signatures, including a large 'X' and illegible cursive text.*

no none 779-10-9697 Harry Baker same as item 13

Frederick R. Branson Julia Haynes

Id. Rt. Geo. Ft. Wash. x 9330 Lancelot Rd.

Clinton Southern Maryland Hospital Center Housewife at home

Washington D.C. USA Prince George

Female Case.

12 11 1932

Margaret H. Baker



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 2 1 8 9 7 4				
1. DECEASED NAME (TYPE OR PRINT)					20. DATE OF DEATH				
FIRST MARY MARGARET LAST BALDWIN					MONTH 7 DAY 13 YEAR 82				
3. SEX Female					2b. HOUR 6:42 P.M.				
4. RACE CAUCASIAN					6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.				
5. DATE OF BIRTH 8 12 99					IF UNDER 1 YEAR MONTHS DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WISCONSIN					IF UNDER 24 HRS. HOURS MIN.				
7b. CITIZEN OF WHAT COUNTRY? U.S.A.					9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.				
10. CITY OR TOWN OF DEATH HYATTSVILLE					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL MANOR					12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MARYLAND					13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13c. COUNTY MONTGOMERY					13d. CITY OR TOWN POTOMAC				
13e. STREET ADDRESS 11816 BECKET STREET					20854				
14. FATHER'S NAME FIRST WILLIAM MIDDLE LAST CLOUSE					15. MOTHER'S MAIDEN NAME FIRST HANNAH MIDDLE LAST O'SHEA				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 309 16 4816				
17. INFORMANT ADDRESS M. MARY LACH SAME AS 13 DAUGHTER									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Pneumonia - Arterial									
DUE TO, OR AS A CONSEQUENCE OF (b) Endometrial Carcinoma									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 1980, 19 to 7-11, 1982, that (I) (we) lost saw the deceased alive on 7-4, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22c. DATE SIGNED 7-13-82									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard B. Perry, MD									
22e. ADDRESS 1145 19th St. N.W.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL									
23b. DATE 7/16/82									
23c. NAME OF CEMETERY OR CREMATORY COVINGTON MEMORIAL GONS. FT. WAYNE INDIANA									
23d. LOCATION CITY OR TOWN COUNTY STATE									
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901									
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 22 1982									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 8 9 7 5

FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) JOHN ALLISON BALLENGER SR.			2a DATE OF DEATH MONTH DAY YEAR JULY 03 1982			2b HOUR 5:35PM			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR FEB. 1 1910		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENNESSEE		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.			
10 CITY OR TOWN OF DEATH LAUREL		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER LAUREL BELTSVILLE HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BUICK DEALERSHIP		12b KIND OF BUSINESS OR INDUSTRY AUTO.	
13a STATE MD.			13b COUNTY P.G.		13c CITY OR TOWN LAUREL		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST JERRY M. BALLENGER			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOCIA HINES			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b SOCIAL SECURITY NO 110-12-0528			17 INFORMANT BARBARA A. MERCURIO			4899 DUSTIN ROAD 20866 BURTONSVILLE, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diphtheria Anomym of Circle of Throat</i> 4373 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hr									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a DATE OF OPERATION 6/1/82		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Resection of Stomach				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 19 70 to July 3 19 82, that (I) (we) lost saw the deceased alive on July 3 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Robert S. McCeney M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 7/3/82			
22d PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT S. MCCENEY				22e ADDRESS 402 MAIN ST. LAUREL, MD. 20707					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 7/7/82		23c NAME OF CEMETERY OR CREMATORY ST. MARYS CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE LAUREL P.G. MD.			
24 FUNERAL DIRECTOR FLECK LAUREL FUNERAL HOME INC. 7601 SANDY SPRING RD. LAUREL, MD. 20707				25 DATE REC'D. BY REGISTRAR (S) REGISTRARS SIGNATURE JUL 6 1982 Frances San Martin					

RECEIVED  
JAN 10 1964

TO: DIRECTOR

FROM: SAC, NEW YORK



SUBJECT: [Illegible]

RE: [Illegible]

[The body of the document contains several paragraphs of extremely faint, illegible text, likely due to fading or poor reproduction quality. The text appears to be a memorandum or report.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 18976	
1. DECEASED NAME (TYPE OR PRINT) <b>SHELBY J. BARNES</b>						2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY 7 YEAR 1982		2b. HOUR 5:54			
3. SEX <b>M.</b>	4. RACE <b>BLK.</b>	5. DATE OF BIRTH MONTH 6 DAY 13 YEAR 50	6. AGE (IN YEARS) LAST BIRTHDAY 32 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH 7 DAY 31 YEAR 1982		2d. HOUR a M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's Co.</b> MD.					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George's Gen. Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>WELDER</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MD</b>		13b. COUNTY <b>P.G.C.</b>		13c. CITY OR TOWN <b>BOWIE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8207 MERCURY LANE</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>SHELBY BARNES</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FRANCES HAMILTON</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17. INFORMANT <b>BARBARA A. BARNES - SAME AS 13e</b>		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Undetermined</b> IMMEDIATE CAUSE (a) <b>7999</b> Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last. (b) <b>7999</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>7999</b> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>8-1-82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>				ADDRESS <b>111 Penn St., Balto., Md. 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <b>8-5-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. National</b>		23d. LOCATION CITY OR TOWN <b>Beltsville</b> COUNTY <b>P.G.</b> STATE <b>MD</b>					
24. FUNERAL DIRECTOR NAME <b>W.S. Washington</b> ADDRESS <b>4425 Bonaventure Ave N.E.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 11 1982</b>		REGISTRAR'S SIGNATURE 					

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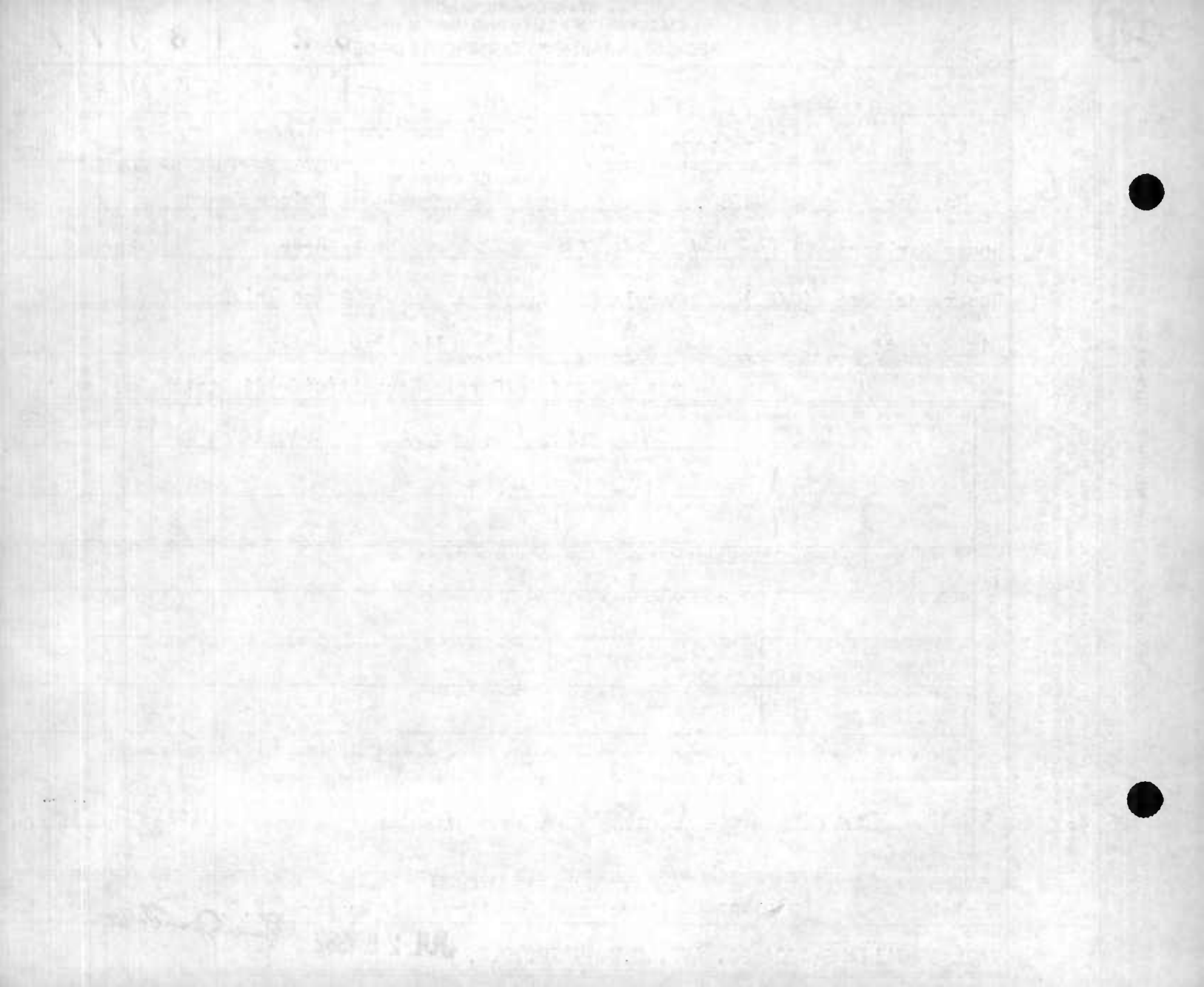
DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND									
DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
REG. NO. 82 18977									
1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2b. DATE KNOWN OF DEATH		ESTIMATED	
		Moses M BARNETT				7 24 82		9 30 AM	
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YR. MONTHS DAYS	
				5-10-1903				IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED XX NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
No. Car.		U.S.A.				Prince George MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Upper Marlboro		No. 4 Staton Dr.		Laborer		Unknown			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Upper Marlboro (P/G.)		Maryland						4 Staton Drive	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Jim Barnett		Ella Day							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No		242-09-2206		Upper Carrie Barnett(wife)#4 Staton Dr., Marl-					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		APPROXIMATE TIME OF DEATH BETWEEN ONSET AND DEATH					
4100		IMMEDIATE CAUSE (a) hyper tension, ASVD		bpr					
Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last.		(b) h/o M I		Z Md.					
		(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED			
SAID A. DARR M		A.D. Deputy				7-24-82			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		7-31-82		Burchwood, Cemetery		Roxboro N.C.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25. DATE REC'D. BY REGISTRAR					
VANN & WILLIAMS, 4804 GA. AVE., N.W., WASH., D.C.				JUL 29 1982					

050-8P  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to make a post-mortem examination.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE														
1. FOR STATE REGISTRAR														
1. DECEASED NAME					2a. DATE OF DEATH									
FIRST MIDDLE LAST					MONTH DAY YEAR HOUR									
Alice D. Beavers					7-28-82 7:10 pm									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR						
Female		White		4 8 1916		66		MONTHS DAYS HOURS MIN.						
8. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 24 HRS.					
Maryland		USA			NEVER MARRIED		Prince Georges County MD.		IF UNDER 1 YEAR					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY		13. IF UNDER 24 HRS.					
Clinton		Southern Maryland Hospital			Housewife		at home		MONTHS DAYS HOURS MIN.					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. STREET ADDRESS									
13a. STATE					13c. CITY OR TOWN									
Wash., D.C.					3508 Carpenter St. S.E.									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME									
Rayner E. Dove					Eva Suit									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.					17. INFORMANT				
NO					578-10-0114B					John Beavers				
18. CAUSE OF DEATH					19. ADDRESS					20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4239 IMMEDIATE CAUSE (a) Cardio-pulmonary Ulcer +					3508 Carpenter St., S. E.									
DUE TO, OR AS A CONSEQUENCE OF					Wash., D. C.									
(b) Septicemia [Gram Negative]														
DUE TO, OR AS A CONSEQUENCE OF														
(c) Pericardial effusion														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:														
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?				
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED				
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					HOUR A.M. MONTH DAY YEAR					(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
(IF EITHER, NOTIFY MEDICAL EXAMINER)					P.M. 19									
21d. INJURY OCCURRED					21e. PLACE OF INJURY					21f. LOCATION				
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>					(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)					CITY OR TOWN COUNTY STATE				
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>														
22a. I certify that (I, the hospital) attended the deceased from 7/28 7/28 19 82 to 7/28 7/28 19 82, that (I) view the deceased alive on 7/28 7/28 19 82, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) view the body after death.														
22b. SIGNATURE					DEGREE					22c. DATE SIGNED				
A. Ansari MD					MD					7/29/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS									
A. ANSARI MD					10905 FT. WASH. Rd. Suite 207									
					FT. WASH. MD. 20744									
23a. BURIAL, CREMATION, REMOVAL					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY				
Burial					7-31-82					Cedar Hill				
23d. LOCATION					23e. DATE REC'D.					23f. SIGNATURE				
Sutland, Md. J.P. Blum					AUG 4 1982									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 18979	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Charles Henry Beavers, Jr.</b>										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>7-7-82</b>	
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9-23-10</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>71</b> YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>7 11 19 82</b>		2b. HOUR <b>3P</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.					
10. CITY OR TOWN OF DEATH <b>Temple Hills</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4318 Sheldon Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ambulance Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy Dept</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince George</b>		13c. CITY OR TOWN <b>Temple Hills</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4318 Sheldon Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Henry Beavers, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary McDermott</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-44-4091</b>		17. INFORMANT ADDRESS <b>Teresa G. Beavers 4318 Sheldon Ave. Temple Hills, Maryland</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>3030 IMMEDIATE CAUSE (a) Ethylism</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED 7/11/1982			
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez M.D.</b>				ADDRESS <b>5009 Rayburn Ct., Temple Hills, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/14/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Pr. Geo. Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>George P. Kalas Funeral Home</b>				ADDRESS <b>6160 Oxon Hill Rd. Oxon Hill, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>Jul 16 1982</b>		25b. REGISTRAR'S SIGNATURE <i>James Van Nostrand</i>	

Washington, D. C. U.S.A.

Ambulance Driver U.S. Navy Dept

1318 Sheldon Avenue

x

Prince George Temple Hills

Melrose

Mary

Beverly, Dr.

Henry

Johnnie

1318 Sheldon Ave.  
Temple Hills, Maryland

James G. Beverly

21-11-1991

No

Dr. Geo. Maryland

William

Geary Hill Cemetery

7/11/82

Initial

6160 Oxon Hill Rd.  
Oxon Hill, Md.

George F. Elisha  
Oxon Hill Home

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			2b. HOUR
MARY ALICE BEGGS						7 14 82			3 45 P M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. UNDER 24 HRS	
FEMALE	CAUCASIAN	SEPT 7, 1894		87 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
WASHINGTON, D.C.		U.S.A.				PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
HYATTSVILLE		MANOR CARE NURSING HOME				FILE CLERK		HASKINS INF. BUREAU	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. INSIDE CITY LIMITS?			13c. STREET ADDRESS			
MARYLAND MONTGOMERY SILVER SPRING			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			10402 PROCTER STREET 20901			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST			FIRST MIDDLE LAST						
GEORGE R.F. SMITH			ALICE V. PASQUALL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17. INFORMANT ADDRESS			
NO			577-48-4220			MILDRED A. DAUGHERTY SAME AS 13 DAUGHTER			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) CARDIAC ARREST									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			HOUR A.M. MONTH DAY YEAR						
			P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 11, 19 81, to JULY 14, 19 82, that (I) (we) last saw the deceased alive on JULY 14, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) know the body after death.									
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
MYRON L. LENKIN			MD					7/14/82	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22d. ADDRESS						
MYRON L. LENKIN			SILVER SPRING, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY
BURIAL			7/16/82		FT. LINCOLN CEM.		BRENTWOOD		PRI GEO MD.
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS			JUL 22 1982			Name J. J. J.			
FRANCIS J. COLLINS			500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Jean H. Bennett				JULY 23, 1982		4:24 a.m.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS	
FEMALE	WHITE	JANUARY 22, 1919		63 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Newfoundland	UNITED STATES			PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Camp Springs	MALCOLM GROW USAF MEDICAL CENTER		HOUSEWIFE		Own Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS			
MARYLAND	PRINCE GEORGE'S	HYATTSVILLE	xx	2015 BARLOWE PL			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
JOHN		Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS Address Same as No# 13e.	
NO		218-84-2257		JAMES L. BENNETT			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u> CIRCULATORY COLLOPSE							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Colon Carcinoma</u> COLON CARCINOMA							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 17</u> , 19 <u>82</u> , to <u>JULY 23</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>JULY 23</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Steven L. Chambers</u> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED JULY 23, 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN L. CHAMBERS, CPT, USAF, MC				22e. ADDRESS MALCOLM GROW USAF MC, AAFB, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 27, 1982		23c. NAME OF CEMETERY OR CREMATORY Lakemont Mem. Gardens		23d. LOCATION CITY OR TOWN STATE	
				Cem. Davidson		Md.	
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Md.				25a. DATE OF BURIAL JUL 28 1982		25b. REGISTRAR'S SIGNATURE	



F. Gasch's Sons L.L.B.A. Walsley, Wb.

July 27, 1882 Lakewood New, Garden City, N.Y. Wb.

Unknown

Bennett



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lillian P. Bennett		2a. DATE KNOWN OF DEATH ESTIMATED July 12, 1982		2b. HOUR 7:45 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 27, 1896	6. AGE (IN YEARS) (LAST BIRTHDAY) 85 YRS.	IF UNDER 24 YRS. MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6800 Parkwood Street #202	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland	13b. COUNTY P.G. Co.	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 6800 Parkwood St. #202
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Lee Parker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Augusta Bowman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	16b. SOCIAL SECURITY NO. None	17. INFORMANT ADDRESS 426 Colonial Ridge Evelyn Paxton/Daughter/Arnold, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4029 DUE TO, OR AS A CONSEQUENCE OF (b) <u>hx of high blood pressure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>and ASVD</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE SAID A. DAE MD		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER		DATE SIGNED July 13/82
EXAMINER'S NAME (TYPE OR PRINT) Dr. Said A. Dae, M.D.		ADDRESS 5632 Annapolis Rd. Bladensburg, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE July 15/82	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Co. Maryland	
24. FUNERAL DIRECTOR NAME Chambers Funeral Home		ADDRESS Riverdale, Maryland		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR FOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 1 8 9 8 3	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RALPH BLASI						2a. DATE KNOWN OF DEATH ESTI- MATED		MONTH DAY YEAR HOUR 7 29 82 7 AM	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 5 3 17		6. AGE (IN YEARS) LAST BIRTHDAY 64 65		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Pr. Geo. MD.					
10. CITY OR TOWN OF DEATH Brentwood		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4523-38th Ave.,				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Molder		12b. KIND OF BUSINESS OR INDUSTRY -			
13a. STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Brentwood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4523 - 38th Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST John Blasi				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT Raymond Blasi - 19th Ave., Cape Cor				ADDRESS 3378-Southeast Florida			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 3459 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. ASVD DUE TO, OR AS A CONSEQUENCE OF (c) EPLIPSY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Florida	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER		DATE SIGNED 7-29			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/2/1982		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.			
24. FUNERAL DIRECTOR NAME		Nalley's F. H. Inc.		ADDRESS Mt. Rainier, Md.		25a. DATE REC'D. BY REGISTRAR AUG 5 1982		25b. REGISTRAR'S SIGNATURE John J. Lough			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 8 9 8 4			
FOR 1. STATE REGISTRAR					CERTIFICATE OF DEATH								
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					MONTH DAY YEAR		2b. HOUR	
ROBERT EUGENE BOOTH					JULY 4, 1982					3:30pm			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		WHITE		AUGUST 10, 1933			48			MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
PENNSYLVANIA		UNITED STATES					PRINCE GEORGE'S COUNTY					MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
ANDREWS AFB		MALCOLM GROW USAF MEDICAL CENTER								INTERNAL AUDITOR		MILITARY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RD 1 BOX 410					
DELAWARE		KENT		WYOMING									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME								
EDWIN		BOOTH		ERMA		BEHNKEN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT					ADDRESS	
YES					1951-1971		FRANCINE M BOOTH					19934 RD 1 BOX 410 WYOMING, DE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 2051 IMMEDIATE CAUSE (a) BLAST CRISIS OF CHRONIC GRANULOCYTIC LEUKEMIA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
			P.M. 19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from JUNE 30 19 82, to JULY 4 19 82, that (I) (we) lost saw the deceased alive on JULY 4 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED		4 JUL 82	
22b. SIGNATURE					DEGREE								
Richard G Snyder					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS								
RICHARD G SNYDER, CAPT., USAF					MALCOLM GROW USAF MED CEN AAFB, MD 20331								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial			7-9-82		Odd Fellows Cemetery			Camden, Kent De					
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE			
Henry Williamson					FEDERALSBURG, Md.					JUL 8 1982			

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BP  
DHMH - 16 50M 1/81  
(VRA 15, 4)

*Medical Certificate Notified*  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. The deceased must be examined by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
CERTIFICATE OF DEATH											
REG. NO.											
1. FOR STATE REGISTRAR EDMUND DONALD BOUDREAU					2a. DATE OF DEATH JULY 25, 1982						
3 SEX MALE					4 RACE WHITE		5 DATE OF BIRTH OCTOBER 7, 1911		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS					7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.		
10 CITY OR TOWN OF DEATH ANDREWS AFB					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHARMASIST		12b. KIND OF BUSINESS OR INDUSTRY MEDICINE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE NEW JERSEY		13b. COUNTY WARREN		13c. CITY OR TOWN BELVEDERE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS PO BOX 278			
14. FATHER'S NAME EDMUND JOSEPH BOUDREAU					15. MOTHER'S MAIDEN NAME EMMA ELIZABETH MIOTT						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					16b. SOCIAL SECURITY NO. 145-07-0624		17 INFORMANT MARJORIE BOUDREAU, PO BOX 278, BELVEDERE				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <i>Asystole with Electromechanical Dissociation</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DISSOCIATION											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 25</u> , 19 <u>82</u> , to <u>JULY 25</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>JULY 25</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Ray D. Morris</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>X 25 July 82</i>			
22d. PHYSICIAN'S NAME (TYPE PRINT) RAY D. MORRIS, CAPT, USAF, MC					22e. ADDRESS MALCOLM GROW USAF MED CEN, AAFB, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>7-29-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Patrick's Catholic Cem</i>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <i>Belvedere Prince Georges N.S.</i>				
24. FUNERAL DIRECTOR NAME <i>Joseph L. Russ</i>					ADDRESS <i>222 W. North Ave.</i>		25a. DATE REC'D BY REGISTRAR <i>JUL 27 1982</i>				
							25b. REGISTRAR'S SIGNATURE <i>Frances Santhron</i>				



Aspirin 5.00  
Aspirin 5.00

Aspirin 5.00

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.				8 2 1 8 9 8 6					
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
Robert		Page		Bradshaw, Sr.				7 3 82		9:55 P.M.	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?	
Male		White		March 21, 1901		81		Virginia		USA	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Prince Georges		MD.		Lanham		Magnolia Gardens Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Express Mess. Ret.		Express Agency									
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
Maryland		Prince Georges		Adelphi		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1711 Langley Way,			
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS			
Rufus P. Bradshaw		Lena Page		no		577-03-9246		Evelyn H. Bradshaw-wife-(same as 13e)			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>											
1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>LUNG CARCINOMA</u>										6 MONTHS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CORONARY ARTERY DISEASE</u>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21a INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21b PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c LOCATION STREET CITY OR TOWN COUNTY STATE							
22 I certify that (I) (this hospital) attended the deceased from <u>AUGUST</u> 19 <u>72</u> , to <u>JULY</u> 3, 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>JUNE</u> 30, 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22a SIGNATURE <u>Arnold G. Levy</u> MD						DEGREE		22c DATE SIGNED			
22a PHYSICIAN'S NAME (TYPE OR PRINT)						22b ADDRESS		22c DATE SIGNED			
ARNOLD G. LEVY, M.D.						1106 SPRING ST. SILVER SPRING, MD. 20910		7-3-82			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE					
Burial		7-8-1982		Fort Lincoln Cemetery		Brentwood Pr. Georges Md.					
24 FUNERAL DIRECTOR NAME		24b ADDRESS		24c DATE REC'D. BY REGISTRAR		24d REGISTRAR'S SIGNATURE					
HINES/RINALDI F.V.		11802 NEW HAMPSHIRE AVE. SILVER SPRING, MD. 20910		JUL 8 1982		Frances Van Natter					



Robert	Page	Bradshaw, Jr.
Male	White	March 21, 1901
Virginia	USA	Prince George
Lincoln	Marion's Garden	Marion's Garden
Marion's	Prince George	1791 Lincoln Hwy.
Native	F.	Bradshaw
do	—	177-02-210
		Swain M. Bradshaw wife (same as 177)

Serial 17-2-1932 Fort Lincoln Cemetery Greenwood R. Georgia, GA.

177-02-210 Swain M. Bradshaw wife (same as 177)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Charles Henry Brager</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 24, 1982</b>			2b. HOUR <b>7:10 A.M.</b>		
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 23, 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maine</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD.		
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Television</b>		
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Charles Waldorf</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>2662 Upbrook Court</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unavailable</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unavailable Olson</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 2</b>		17. INFORMANT ADDRESS <b>Dorothy M. Brager Same as Line 13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: <b>4920 IMMEDIATE CAUSE (a) Respiratory failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <b>Emphysema.</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>6-17-1982</b> to <b>7-24-1982</b> , that (I) (we) last saw the deceased alive on <b>7-23-1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>G. Shankar Rath</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>7-24-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. Shankar Rath, M.D.</b>				22e. ADDRESS <b>Charles Professional Center, Waldorf, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>7-24-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington D.C. Wash. DC</b>		
24. FUNERAL DIRECTOR NAME <b>Huntt Funeral Home Waldorf, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 28 1982</b>		25b. REGISTRAR SIGNATURE <i>Charles G. Rath</i>		

MEDICAL CERTIFICATION

Hunt Funeral Home, Detroit, Michigan

7-24-82 Lee Street, Washington D.C.

Charles International Center, Detroit, Michigan

Charles International Center, Detroit, Michigan

7-24-82

Yes

2

002-11-2729, Dorothy M. Strader, same as line 13

Unavailable

Unavailable

Yes

Michigan

Charles

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

July 24, 1982

Michigan

Michigan

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 18988			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) <i>Willis Branch Bragg</i>						2a. DATE KNOWN OF DEATH <i>7-28 1982</i>		2b. HOUR					
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>11-5-22</i>		6. AGE (IN YEARS) <i>59</i> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD.				
10. CITY OR TOWN OF DEATH <i>Suitland</i>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1765 Lewis Avenue Apt. D</i>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Security Guard</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>DC Govt.</i>		
13a. STATE <i>Md.</i>			13b. COUNTY <i>PG</i>		13c. CITY OR TOWN <i>Suitland</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>2725 Lewis Avenue</i>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Bragg</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sadie McKinney</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>				16b. SOCIAL SECURITY NO. <i>226-28-8344</i>		17. INFORMANT ADDRESS <i>John Bragg, Brother, Same as Above</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <i>4292 Diabetic arteriosclerosis Cardiovascular disease</i> IMMEDIATE CAUSE (a) <i>4292</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Emphysema, Ethanol history</i>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>						TITLE (SPECIFY) <i>Deputy</i>			MEDICAL EXAMINER			DATE SIGNED <i>7/28/82</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez M.D.</i>						ADDRESS <i>5009 Rayburn Ct., Temple Hills, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>7-31-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Wash. Natl. Cem.</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland, P.G., Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>Robt E Wilhelm</i> ADDRESS <i>4308 Suitland Rd., Suitland, Md.</i>						25a. DATE REC'D. BY REGISTRAR <i>AUG 4 1982</i>		25b. REGISTRAR'S SIGNATURE <i>James J. Nathan</i>					

BP

20-8-00 10-11-05

Bill: 10-11-05

10-11-05

10-11-05

10-11-05

10-11-05

10-11-05

10-11-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

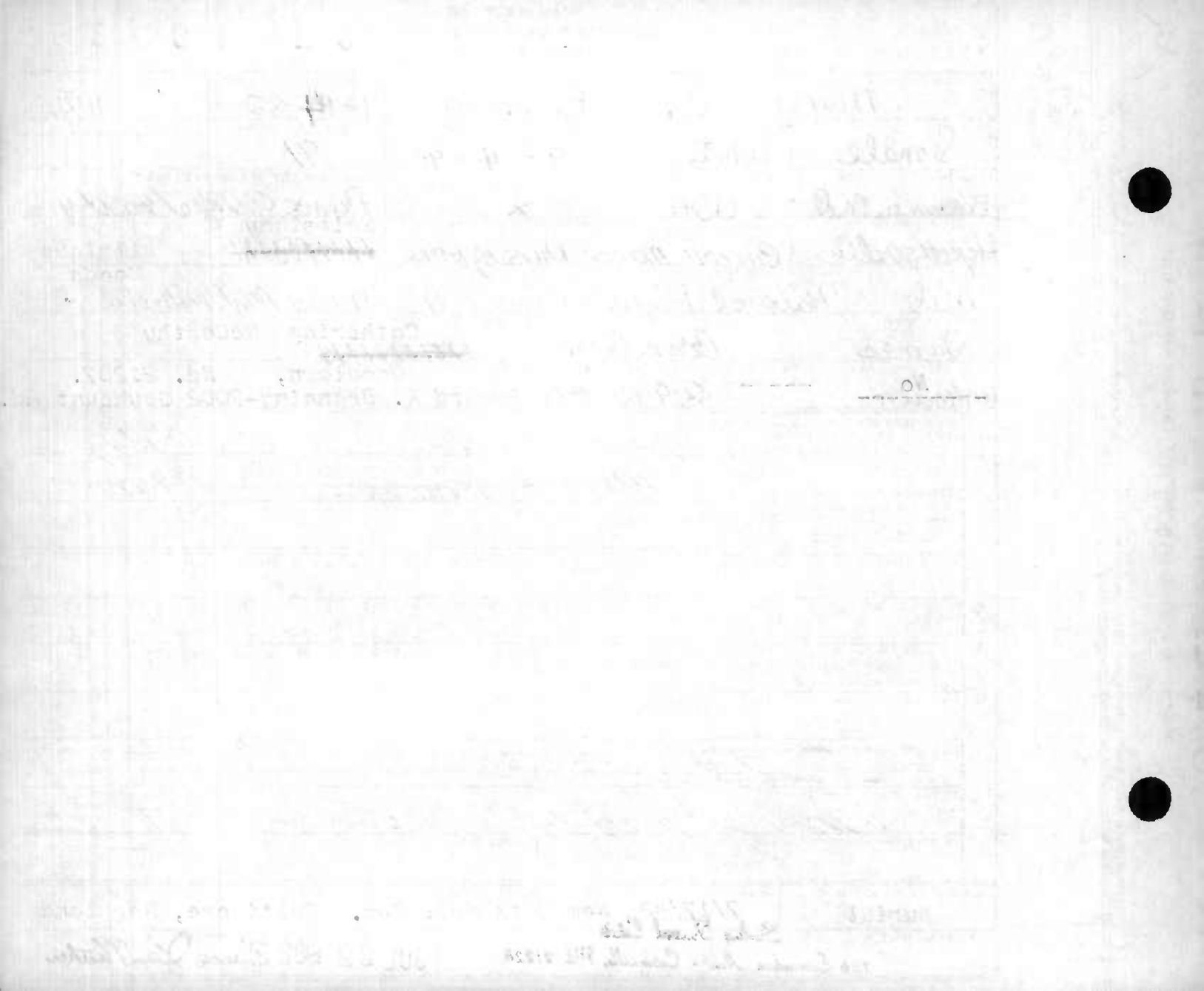
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

BP

DHMM-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 8 9 8 9				
1 - FOR STATE REGISTRAR					REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mary C. Branning</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>7-14-82</b>					2b. HOUR <b>11:58 AM</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9-4-90</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 74 HRS. HOURS MIN.			
9. BIRTH PLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore MD</b>		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges County MD</b>								
13. CITY OR TOWN OF DEATH <b>Hyattsville</b>		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Manor Nursing Home</b>		15. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges County MD</b>		16. KIND OF BUSINESS OR INDUSTRY <b>Religious Goods</b>								
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE <b>Md</b>		17b. COUNTY <b>Howard</b>		17c. CITY OR TOWN <b>Highland</b>		17d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		17e. STREET ADDRESS <b>7225 Mink Hollow Rd</b>						
18. FATHER'S NAME FIRST MIDDLE LAST <b>James Connelley</b>		19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine McCarthy</b>		20. ADDRESS <b>Woodlawn, Md. 21207.</b>										
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>No</b>		22. SOCIAL SECURITY NO. <b>219-10-3445</b>		23. INFORMANT <b>Edward A. Branning-7002 Gaymount Rd.</b>										
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4850</b> IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bronchopneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>1 day</b> <b>1 wks</b>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
25. DATE OF OPERATION				26. CONDITION FOR WHICH OPERATION WAS PERFORMED				27. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
32. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				33. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)				34. LOCATION STREET CITY OR TOWN COUNTY STATE						
35. I certify that (I) (the hospital) attended the deceased from <b>7/6</b> 19 <b>82</b> to <b>7/14</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>7/4</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
36. SIGNATURE <b>Dr. J. P. ...</b>				37. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				38. DATE SIGNED <b>7/15/82</b>						
39. PHYSICIAN'S NAME (TYPE OR PRINT)				40. ADDRESS										
41. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				42. DATE <b>7/17/82</b>		43. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>				44. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>				
45. FUNERAL DIRECTOR NAME <b>Starling Funeral Home</b>				46. ADDRESS <b>736 Edmondson Ave. - Catonsville, Md. 21228</b>				47. DATE REC'D. BY REGISTRAR <b>JUL 22 1982</b>				48. REGISTRAR'S SIGNATURE <b>Frances Jan Nathan</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		7 10 82		8:44 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
MALE		White		11 11 1902		72 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
TODD SCHENCK		U.S.				PRINCE GEORGES			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
CLINTON		6410 MAJOR CIRCLE DRIVE		RAILROAD CLERK		RAILROAD EMP.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MARYLAND		PRINCE GEORGES		CLINTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6410 MAJOR CIRCLE DRIVE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
GUSTAV		Lena Bundelman		NO.		718-18-7362		IDA BRAUNER 6410 MAJOR CIRCLE DRIVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY		PART I. DEATH WAS CAUSED BY		PART I. DEATH WAS CAUSED BY		PART I. DEATH WAS CAUSED BY		PART I. DEATH WAS CAUSED BY	
IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)	
1629 RESPIRATORY FAILURE		1629 RESPIRATORY FAILURE		1629 RESPIRATORY FAILURE		1629 RESPIRATORY FAILURE		1629 RESPIRATORY FAILURE	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
(b) CANCER OF LUNG WITH METASTASIS		(b) CANCER OF LUNG WITH METASTASIS		(b) CANCER OF LUNG WITH METASTASIS		(b) CANCER OF LUNG WITH METASTASIS		(b) CANCER OF LUNG WITH METASTASIS	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
(c)		(c)		(c)		(c)		(c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
GENERALIZED ARTERIO SCLEROSIS		GENERALIZED ARTERIO SCLEROSIS		GENERALIZED ARTERIO SCLEROSIS		GENERALIZED ARTERIO SCLEROSIS		GENERALIZED ARTERIO SCLEROSIS	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 19 75 to July 19 82, that (I) (we) lost saw the deceased alive on June 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE DEGREE		22c. DATE SIGNED					
Joseph P. Caruso MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		7-10-82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Joseph P. Caruso MD		913 PISCATAWAY RD CLINTON MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY			
Burial		July 13, 1982		Ft. Lincoln Cemetery		Bladensburg, Pr. Geo. MD			
24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR	
Lee Funeral Home, Inc.		Lee Funeral Home, Inc.		Lee Funeral Home, Inc.		Lee Funeral Home, Inc.		Lee Funeral Home, Inc.	
NAME		NAME		NAME		NAME		NAME	
6633 Old Alexander Ferry Road, Clinton, Maryland		6633 Old Alexander Ferry Road, Clinton, Maryland		6633 Old Alexander Ferry Road, Clinton, Maryland		6633 Old Alexander Ferry Road, Clinton, Maryland		6633 Old Alexander Ferry Road, Clinton, Maryland	
25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE		25e. REGISTRAR'S SIGNATURE	
JUL 15 1982		JUL 15 1982		JUL 15 1982		JUL 15 1982		JUL 15 1982	

RECORD - 1910  
No. 10  
The University of Chicago  
Library  
Chicago, Ill.  
1910

THE UNIVERSITY OF CHICAGO  
LIBRARY  
CHICAGO, ILL.  
1910

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 18991	
1. DECEASED NAME (TYPE OR PRINT) <b>Jasper Frederick BURNETTE</b>					2a. DATE KNOWN OF DEATH ESTIMATED <b>7-14-82</b>			2b. HOUR <b>AM</b>			
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>3</b> DAY <b>6</b> YEAR <b>09</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>73</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD <b>7-15-82</b>		2d. HOUR <b>AM</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hillside</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5287 Marlboro Pike Apt 201</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk-Navy Department</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Hillside</b>		13c. CITY OR TOWN <b>Hillside</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST <b>Primus</b> MIDDLE <b>Burnette</b> LAST <b>Burnette</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Hattie</b> MIDDLE <b>James</b> LAST <b>James</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>					
16b. SOCIAL SECURITY NO. <b>578 09 2008</b>			17. INFORMANT ADDRESS <b>Jasper F. Burnette, Jr. - son-12709 Sholton St. Upper Marlboro, Md.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4029 Hypertensive cardiovascular disease</b> IMMEDIATE CAUSE (a) <b>4029</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>			TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER			DATE SIGNED <b>7-15-82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez MD</b>			ADDRESS <b>5609 Bayview Ct., Camp Springs, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>July 19, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cemetery-Suitland, Md.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Stewart Funeral Home-4001 Benning Rd. N.E.</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 23 1982</b>								



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 2 1 8 9 9 2

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR							
Frank Wendell Campbell								7 21 19 82								M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR			
Male		Black		May 15, 1966		16 YRS.						7 21 19 82								11:31 P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
				USA								Prince George's County, MD											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Cheverly				Prince George's General Hospital								None				None							
13a. STATE								13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md								P.G.		Ft. Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1464 Potomac Heights Drive									
14. FATHER'S NAME				MIDDLE				LAST				15. MOTHER'S MAIDEN NAME				MIDDLE				LAST			
Frank								Campbell (deceased)				Joan				Ingram							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS											
No				Unknown				Mr. Willie F. Jackson/step-father/same															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of neck with transection of cervical spinal cord DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?									
														YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <del>XX</del> MONTH DAY YEAR 10:20 M. 7 21 19 82				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Passenger in auto/fixed object impact															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street				21f. LOCATION STREET Rt. 210N				CITY OR TOWN Friendly				COUNTY P.G.				STATE MD.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Deputy Chief										DATE SIGNED 7/22/82									
EXAMINER'S NAME (TYPE OR PRINT)				Thomas D. Smith, M.D.										ADDRESS 111 Penn St. Balto., MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7-28-82				23c. NAME OF CEMETERY OR CREMATORY Church				23d. LOCATION CITY OR TOWN Floyd, Va.				COUNTY STATE							
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE															
John T. Rhines Co, 3015 12th St., N.E., D.C.				20 JUL 29 1982				Thomas D. Smith															

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-357-7474.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 8 9 9 3				
1 - STATE REGISTRAR					CERTIFICATE OF DEATH									
I. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR				
FIRST MIDDLE LAST					MONTH DAY YEAR					HOURS MIN.				
GOLDIE W. CARL					JULY 8 1982					7 P.M.				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.				
Female		Caucasian		Feb. 2, 1893		84		MONTHS DAYS		HOURS MIN.				
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
W. Va.		U.S.A.				PRINCE GEORGE'S COUNTY MD.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
CHEVERLY		PRINCE GEORGE'S GENERAL HOSPITAL								homemaker		-		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b. CITY OR TOWN		13c. STREET ADDRESS		
13a. STATE										13b. CITY OR TOWN		13c. STREET ADDRESS		
Md. Pr. Geo. Brentwood										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3506 - Taylor St.		
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Ira Frame					Hattie Daley									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)					17. INFORMANT ADDRESS				
No					213-74-4490					Arthur Carl (same as above)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE														
4149														
DUE TO, OR AS A CONSEQUENCE OF														
(b) RECURRENT VENTRICULAR TACHYCARDIA														
DUE TO, OR AS A CONSEQUENCE OF														
(c) ANOXIC ENCEPHALOPATHY														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10														
SICK SINUS SYNDROM														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 6.09.1982 to 7.8.1982, that (I) (we) last saw the deceased alive on 7.8.1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE				DEGREE				22c. DATE SIGNED						
V.P. SINGH				M.D. ATTENDING PHYSICIAN				7.9.82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS										
V. P. SINGH				6496 LANDOVER RD LANDOVER MD 20785										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial				7/12/1982		Mt. Prospect Cem.				Hickory Penna.				
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE						
Nalley's F.H. Inc.				Mt. Rainier, Md.				JUL 14 1982						



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 8 9 9 4  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		07-21-82		10:27P <sub>M</sub>	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR November 2, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 6008 Arbroath Drive		14. FATHER'S NAME FIRST MIDDLE LAST Charles Hatfield		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Wilson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Mrs. Marie Whitmore		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASHD DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15-30 min					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/21 1982, to 7/21 1982, that (I) (we) last saw the deceased alive on 7/21 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles F. Colao		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/24/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. C. COLAO		22e. ADDRESS 3710 RIVIERA STREET, MARLOW HEIGHTS, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 24, 1982		23c. NAME OF CEMETERY OR CREMATORY King Knob Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Harrisville West Virginia	
24. FUNERAL DIRECTOR NAME ADDRESS Lee Funeral Home Inc. 6633 Old Alexander Ferry Road Clinton, Md.				25a. DATE REC'D. BY REGISTRAR JUL 27 1982			
				25b. REGISTRAR'S SIGNATURE James Santherton			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 18995	
1. DECEASED NAME (TYPE OR PRINT) Leticia Yvette Carson						2a. DATE KNOWN OF DEATH 7. 1 1982		2b. HOUR 7:16P			
3. SEX FEMALE	4. RACE NEGRO	5. DATE OF BIRTH 12 12 1970	6. AGE (IN YEARS) 11 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 7 1 1982		2d. HOUR 7:16P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.					
10. CITY OR TOWN OF DEATH Forestville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7606 Mane Lane				12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD						13b. CITY OR TOWN P.G.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13d. STREET ADDRESS 7606 MANE LANE											
14. FATHER'S NAME FRED				15. MOTHER'S MAIDEN NAME CAROLYN		16. ADDRESS 7606 Mane Lane					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 577-88-6546		17. INFORMANT Carolyn Y. Coleman-Forestville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 9640 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <u>7</u> P.M. MONTH <u>1</u> DAY <u>1</u> YEAR <u>1982</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject drowned in bathtub					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET 7606 Mane Lane		21g. CITY OR TOWN Forestville			
						21h. COUNTY P.G.		21i. STATE Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>H. Guard</i>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 7/2/82			
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.				ADDRESS 111 Penn St. Balto., Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7/7/1982		23c. NAME OF CEMETERY OR CREMATORY Washington National Suitland		23d. LOCATION CITY OR TOWN Maryland			
24. FUNERAL DIRECTOR NAME Morrow & Woodford-1622 11th St. N.W.				25a. DATE REC'D BY REGISTRAR JUL 12 1982		25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>					



MAILED  
JUN 17 1964

RECEIVED  
JUN 17 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 8 2 1 8 9 9 6				
1. DECEASED NAME (TYPE OR PRINT) ELIZABETH A. CARTER					2a. DATE OF DEATH MONTH DAY YEAR 07-21-82			2b. HOUR 9PM M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4-13-1924		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION): 13a. STATE Md. 13b. COUNTY Pr. Geo. 13c. CITY OR TOWN Mt. Rainier					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4215 - 31st Street		
14. FATHER'S NAME FIRST MIDDLE LAST John F. Owens					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella C. Groves				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 198-18-0457		17. INFORMANT 3579 S. River Terrace Sandra A. Cordone (Dtr.) Edgewater, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE UPPER GASTROINTESTINAL BLEEDING</u> 5712 DUE TO, OR AS A CONSEQUENCE OF (b) <u>LAENNEC'S CIRRHOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>7-18</u> , 19 <u>82</u> , to <u>7-21</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>7-20-82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Junette Gibbons</i>					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7-22-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JUNETTE GIBBONS, M.D.					22e. ADDRESS Ste. 202, 1141 VARNUM, N.E., WASH. D.C.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-24-82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.		
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc. Mt. Rainier, Md.					25a. DATE REC'D. BY REGISTRAR JUL 28 1982		25b. REGISTRAR <i>James J. [Signature]</i>		

MEDICAL CERTIFICATION





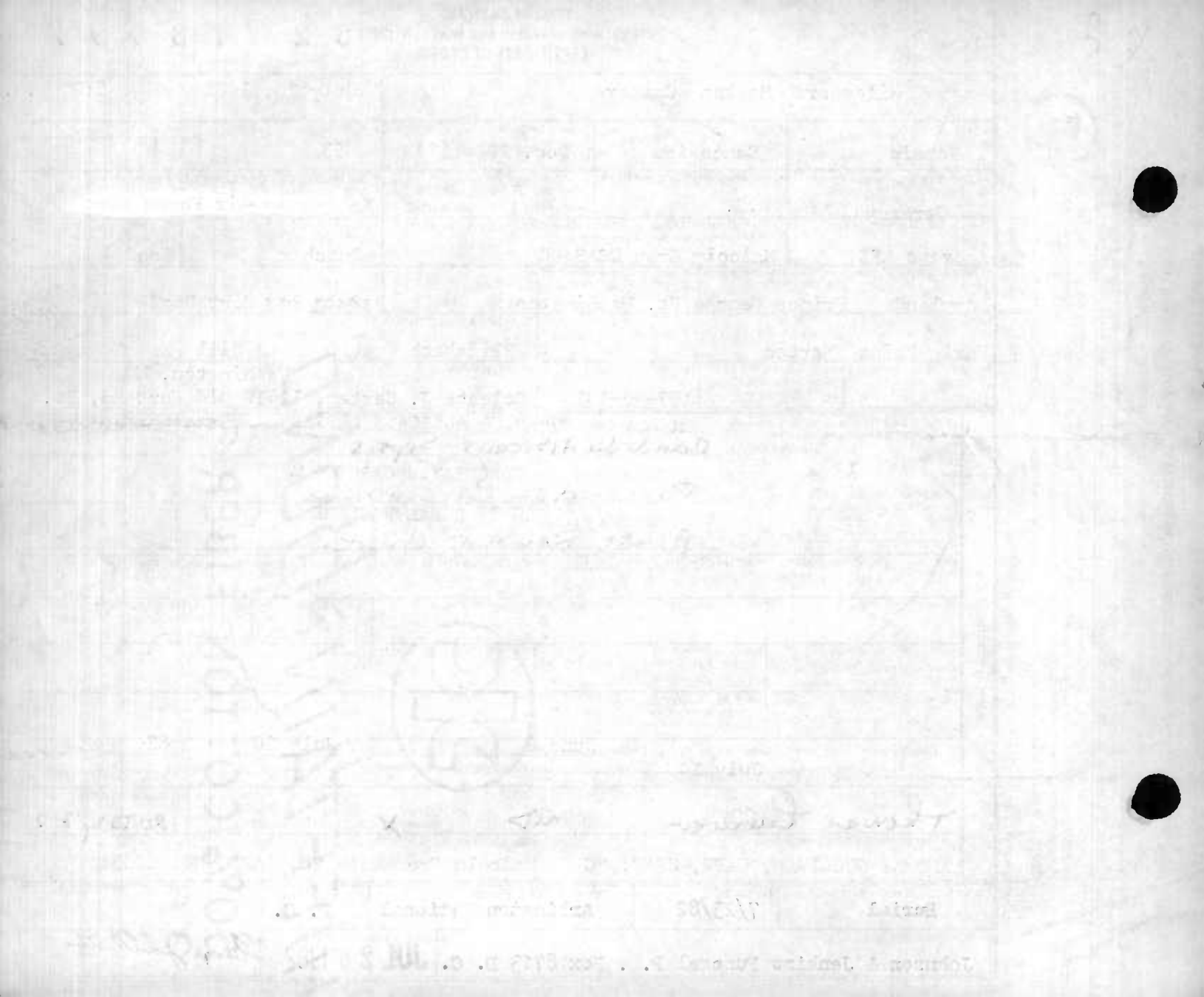
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

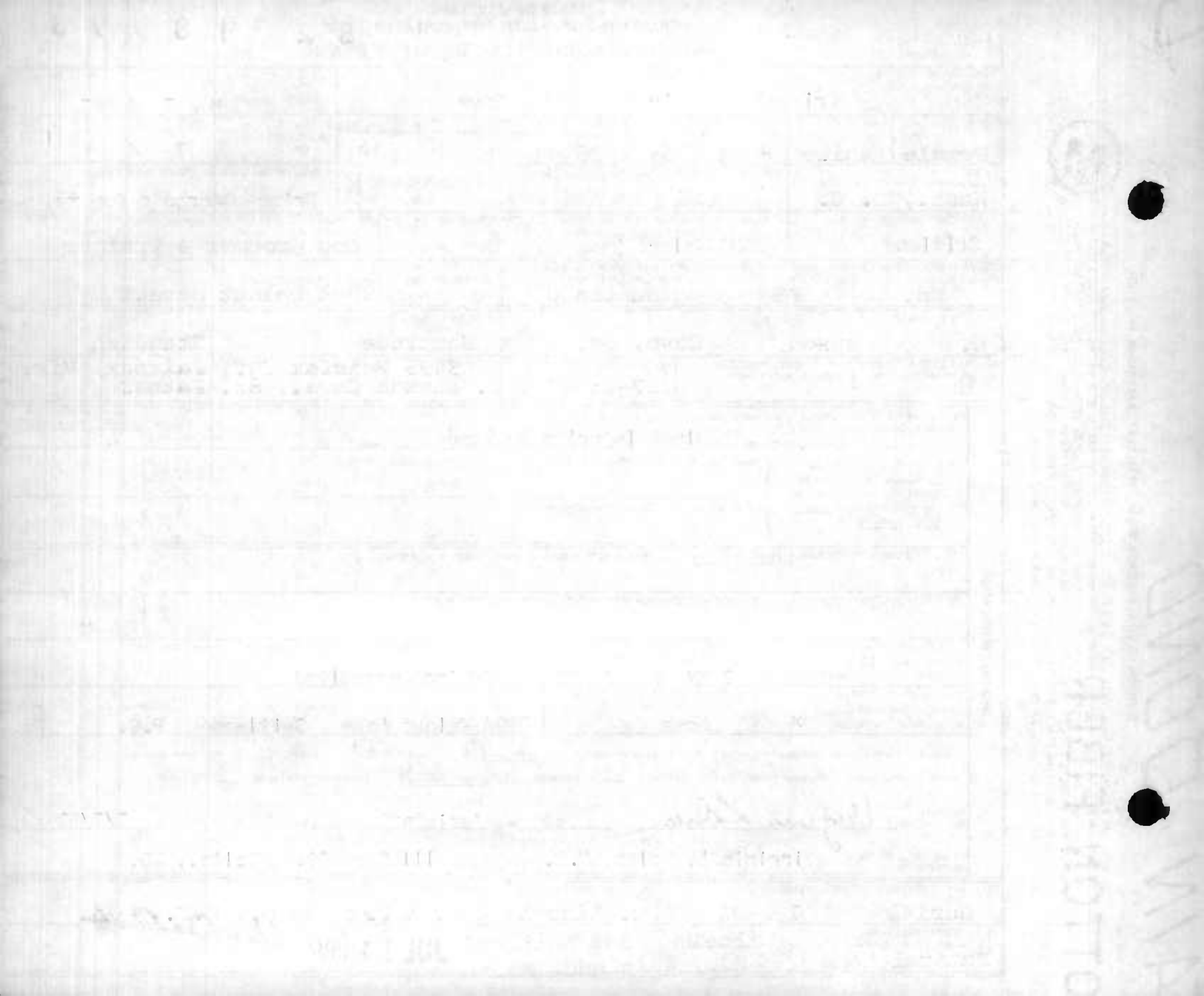
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
REG. NO.										
1. DECEASED NAME (TYPE OR PRINT) <b>Hildegard Merten Carter</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>July 20, 1982</b>					3. HOUR <b>5:00 p.m.</b>
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 20, 1929</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>53</b>		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Andrews AFB</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Malcolm Grow USAF MC</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Butcher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Food</b>		
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Prince George</b>		13c. CITY OR TOWN <b>Ft. Washington</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Karl Heinz Merten</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Dill</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO <b>197-32-1379</b>		17. INFORMANT ADDRESS <b>Celesta J. Carter, 12410 Old Fort Rd, Ft. Washington, MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Candida Albicans Sepsis</b> <b>1579</b> DUE TO, OR AS A CONSEQUENCE OF <b>PANCREATIC CARCINOMA</b> (b) <b>Pancreatic Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF <b>ACUTE RENAL FAILURE</b> (c) <b>Acute Renal Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>June 8</b> , 19 <b>82</b> , to <b>July 20</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>July 20</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Thomas Sullivan</b>					DEGREE <b>MD</b>			22c. DATE SIGNED <b>20 July '82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS SULLIVAN, CAPT, USAF, MC</b>					22e. ADDRESS <b>Malcolm Grow USAF MC, AAFB, MD 20331</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7/23/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>D. C.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Johnson &amp; Jenkins Funeral P.O. Box 8713 D. C.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUL 28 1982</b>					







TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 12 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 18999	
1- STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Donald Benjamin Childs, Sr.								2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7 24 1982		2b. HOUR M 12:40			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Dec. 11, 1953		6. AGE (IN YEARS LAST BIRTHDAY) 28 (RS.)		7. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 24 1982		24 HOUR a M 12:40			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD			
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Metro Driver		12b. KIND OF BUSINESS OR INDUSTRY Subway			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4006 Bunker Hill Road					
14. FATHER'S NAME FIRST MIDDLE LAST Arthur O. Childs						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Jefferson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-74-3512				17. INFORMANT ADDRESS Mrs Wanda P. Childs/4006 Bonker Hi					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 9102 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
MEDICAL CERTIFICATION													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <u>9</u> P.M. MONTH <u>7</u> DAY <u>23</u> YEAR <u>1982</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject in boat which overturned							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) water		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Largo P.G. MD.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 7/25/82					
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7-31-82		23c. NAME OF CEMETERY OR CREMATORY Mt. Gillum Bapt Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Louisiana County, Va.					
24. FUNERAL DIRECTOR NAME ADDRESS Marshall's Funeral Home 4217 9th Street NW, Washington, D.C.						25. DATE REC'D. BY REGISTRAR JUL 30 1982							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					8 2 1 9 0 0 0 CERTIFICATE OF DEATH				
1 DECEASED NAME (TYPE OR PRINT)					2a DATE OF DEATH MONTH DAY YEAR				
Mary Luisa CIOFFI					July 15, 1982				
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7b HOUR	
Female		White		Dec. 16, 1893		88 YRS.		5:08 A.M.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Italy		U.S.A.				Prince George's MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Lanham		Doctors' Hospital of Pr. Geo. Co.				Seamstress		Levy-Adler Co.	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b CITY OR TOWN		13c INSIDE CITY LIMITS?		13e STREET ADDRESS			
None		None		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4409 Lowell St., N.W.			
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME				
Giusseppe Magnotta					Maria unavailable				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS		
no					none		116-20-3213 Son - Frederick T. Cioffi - Same as #13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Compensatory Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardio-respiratory arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Unintentional</u>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>6-4</u> 19 <u>82</u> , to <u>7-15</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>7-14</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE						DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 7/15/82	
22d PHYSICIAN'S NAME (TYPE OR PRINT)						22e ADDRESS			
CIRO A. MONTANEZ, M.D.						3308 Dodge Park Rd., Landover, Md. 20785			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE		
Burial			July 19, '82		Holy Sepulchre Cem.		Rochester N.Y.		
24 FUNERAL DIRECTOR NAME						24b ADDRESS		24c DATE OF BURIAL	
James C. B. [Signature]						DeVol Funeral Home Washington, D.C.		JUL 21 1982	

MEDICAL CERTIFICATION

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A. E. J.

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**Abstract**

58

W. C. Nash

24

SCIENTIFIC

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[illegible]

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1990-1991

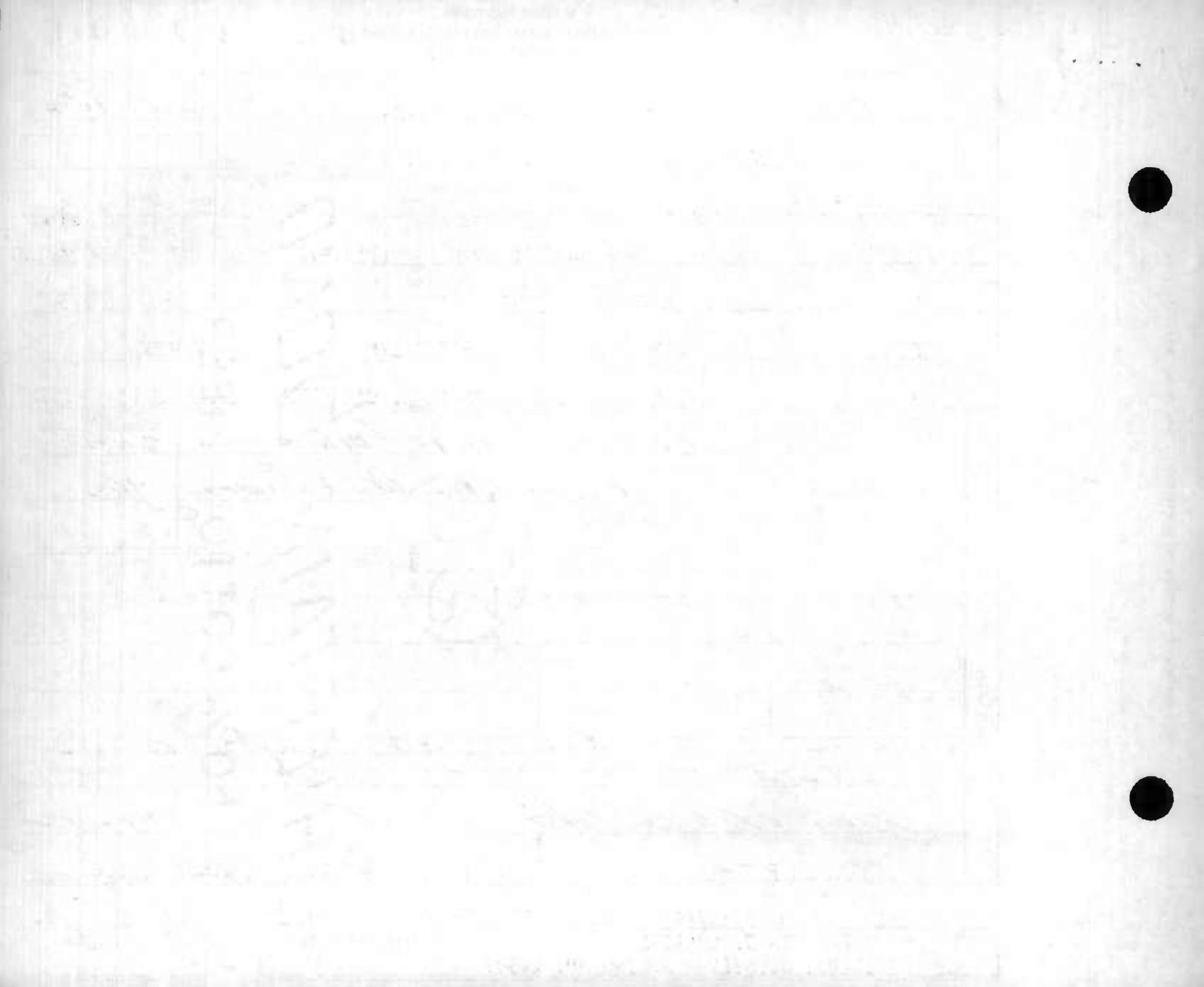
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 9 0 0 1	
1 - STATE REGISTRAR					REG. NO.						
DECEASED NAME (TYPE OR PRINT) STEPHEN A. CLEMENTS, JR.					2a. DATE OF DEATH MONTH DAY YEAR 7-22-82		2b. HOUR 10 <sup>30</sup> AM				
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR NOV 24 1893		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.					
10. CITY OR TOWN OF DEATH HYATTSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL MANOR NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PLATE PRINTER		12b. KIND OF BUSINESS OR INDUSTRY BUR OF ENGRAVING			
13a. STATE MARYLAND					13b. COUNTY PRI. GEORGES		13c. CITY OR TOWN CHEVERLY		13d. INSIDE CITY LIMITS? YES XX NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST STEPHEN A. CLEMENTS					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH McCAULEY		13e. STREET ADDRESS 6407 FOREST ROAD 20785				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 220-44-3385		17. INFORMANT RUSSELL R. CLEMENTS			ADDRESS SAME AS 13 SON		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) <u>Conjunctive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks 1 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 1980</u> , to <u>July 22, 1982</u> , that (I) <u>was</u> lost saw the deceased alive on <u>July 20, 1982</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) <u>view</u> the body after death.											
22b. SIGNATURE <u>James Foster MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7/22/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES FOSTER				22e. ADDRESS 916 19th STREET, N.W., WASHINGTON, D.C.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 7/24/82		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PRI GEO MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE RECEIVED BY FUNERAL DIRECTOR JUL 26 1982				25b. REGISTRAR'S SIGNATURE <u>Charles J. Nathan</u>			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19002	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>James E. Cockrell, sr.</b>										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <b>7 10 82</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH (MONTH DAY YEAR) <b>Jan. 27, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2b. HOUR <b>1130</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>7 11 82</b>		
10. CITY OR TOWN OF DEATH <b>Takoma Park.</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6417 5th. Ave. Takoma Park.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Printer-</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Print Shop</b>	
13a. STATE <b>Maryland.</b>			13b. COUNTY <b>P. G. Co.</b>		13c. CITY OR TOWN <b>Takoma Park.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6417 5 th. Ave. Takoma Pk.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Anderson Cockrell</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maria Pearson</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>W. W. #2 577-26-9380</b>		17. INFORMANT ADDRESS <b>Rose Marie Cockrell-Same as items #13</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1629 Cardio respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of lung with</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>advanced metastasis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>SAID A. DAE</b> M.D. <b>Deputy</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>7-11-82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Said A. Dae</b>				ADDRESS <b>5632 Annapolis Rd. Bladensburg Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>7/12/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P. G. Co. Md.</b>			
24. FUNERAL DIRECTOR <b>Takoma Funeral Home, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>13 1982</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			
25c. ADDRESS <b>254 Carroll St. N. W. D. C.</b>											

BP



James E. Cockrell, Sr.

White, Jan. 27, 1923

Virginia U. S. A. Prince George.

Takoma Park. 4417 5th Ave. Takoma Park. Printer- Print Shop

Maryland. P. O. Co. Takoma Park. 4417 5th Ave. Takoma Pk.

Joseph Anderson Cockrell Maria Pearson

Yes W. W. #2 277-56-9361 Rose Marie Cockrell-Same as item

*Handwritten notes:*  
Cockrell, James E.  
White, Jan. 27, 1923  
Virginia U. S. A.  
Prince George.

Said A. Dace 2632 Annapolis Rd. Bladensburg

Md.

Cremation 7/12/82 Ft. Lincoln Crm. Brentwood, P. O., Md.

Takoma Funeral Home, Inc.

254 Carroll St. N. W. D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

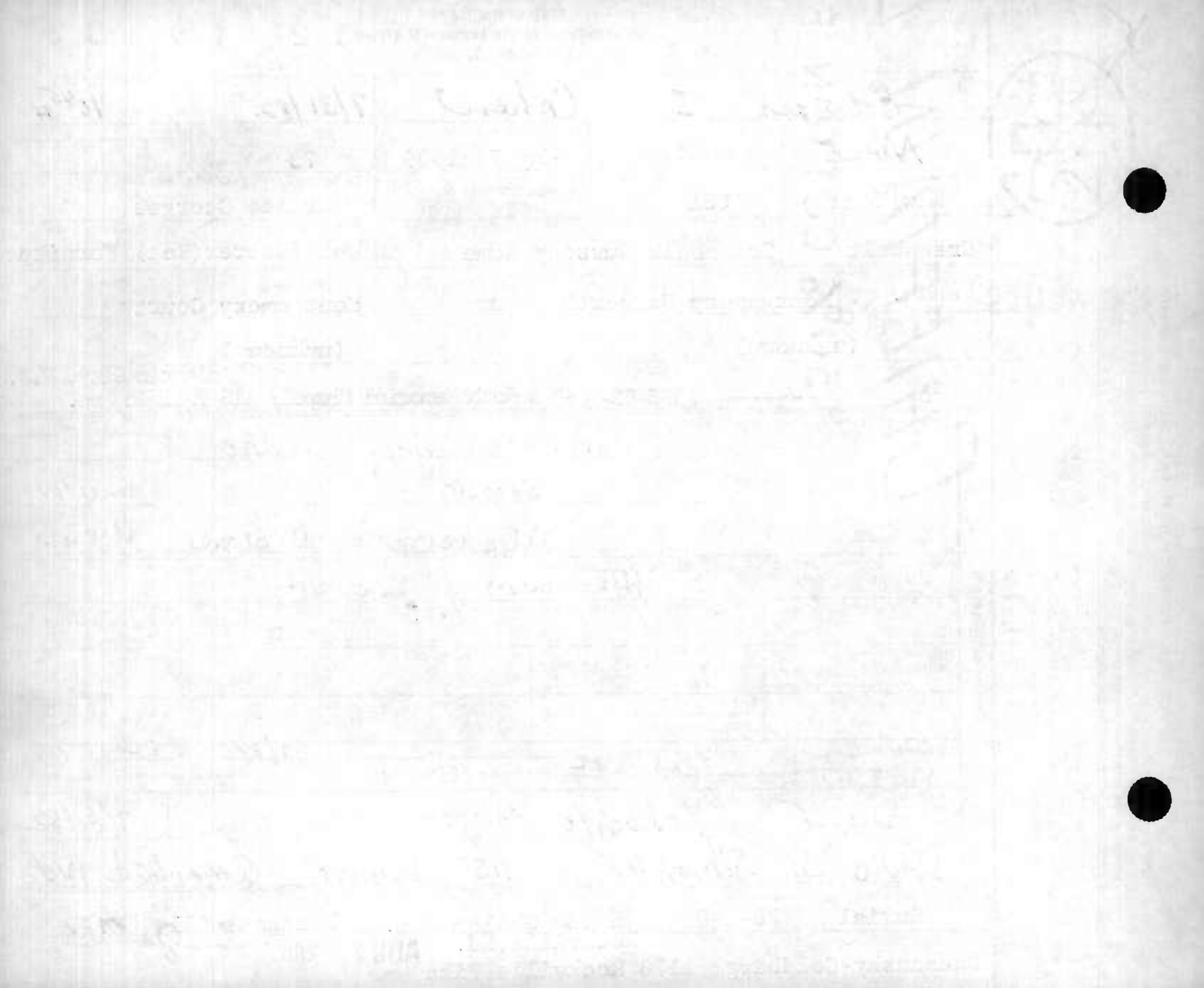
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 9 0 0 3			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>Edward I. Cohen</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>7/31/82</b>		2b. HOUR <b>10<sup>45</sup> A.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 7, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.	
10. CITY OR TOWN OF DEATH <b>Greenbelt</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greenbelt Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Upholsterer (Ret)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Furniture</b>	
13a. STATE <b>Penna.</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Narberth</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>(unknown)</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>(unknown)</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>138-03-7869</b>		17. INFORMANT ADDRESS <b>Atlantic City, N.J.</b> <b>Roth Memorial Chapel; 116 Pacific Ave.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Arrest</b> <b>3310</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Alzheimer's Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>weeks.</b> <b>years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Hypotension / Decubiti</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/28</b> , 19 <b>82</b> , to <b>7/31</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>7/28</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>David S. Schacht</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>7/31/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID S. Schacht</b>				22e. ADDRESS <b>115 Centerville, Greenbelt, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-2-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Emeth Shalom Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pleasantville, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg; 1170 Rockville Pike</b>				25. DATE PREPARED BY REGISTRAR <b>AUG 3 1982</b>			





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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	1	9	0	0	4
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ARTHUR R. COMPTON, Sr.</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>07-14-82</b>				2b. HOUR <b>9:10AM</b>		
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>10-9-1905</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>No. Carolina</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S</b> MD.							
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S GENERAL HOSPITAL</b>							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Bldg. Supervisor</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>			13b. COUNTY <b>Pr. Geo.</b>			13c. CITY OR TOWN <b>Mt. Rainier</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>4227 - 29th Street</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Hayes Compton</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Levie Beaver</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No -</b>						16b. SOCIAL SECURITY NO. <b>578-01-5185</b>		17. INFORMANT ADDRESS <b>Geraldine S. Compton (Wife) above</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURED ABDOMINAL ANEURYSM</b> <b>4413</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>HYPERTENSIVE CARDIO VASCULAR DISEASE</b>																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <b>6-25</b> , 19 <b>82</b> , to <b>7-14</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>7-13 82</b> , 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <b>Mushtaq A. Shah - M.D.</b>										DEGREE		22c. DATE SIGNED <b>7-15-82</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MUSHTAQ A. SHAH</b>										22e. ADDRESS <b>4230 4637 Eastern Ave. Mt. Rainier, Md. 20712</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>7-17-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood, Pr. Geo. Md.</b>						
24. FUNERAL DIRECTOR NAME <b>Nalley's F.H. Inc.</b>										ADDRESS <b>Mt. Rainier, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 20 1982</b>		25b. SIGNATURE <i>[Signature]</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			2b. HOUR
Randall P. Condit						July 20, 1982			1:15P.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		White		MONTH DAY YEAR Sept. 22, 1938		43 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Washington, D.C.		U.S.A.				Prince George's County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Lanham		Doctor's Hosp. of Pr. Geo. Co.				Iron Worker		Construction	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		P.G.		Colmar Manor		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3423 41st. Ave.	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST					FIRST MIDDLE LAST				
Wilbur A. Condit					Azalee Bennett				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS		
No					217-32-0002		Mrs. Wanda Condit Address Same as No# 13e.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) <u>Carcinoma metastasis -</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Colon</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/13</u> , 19 <u>82</u> , to <u>7/20</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>7/19</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
<u>Mehdi Farzin, M.D.</u>					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			July 21, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Mehdi Farzin, M.D.					6201 Greenbelt Rd. College Park, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			7-23-82		Ft. Lincoln Cemetery		Brentwood, P.G. Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR (IN REGISTRAR'S OFFICE)			
F. Gasch's Sons F.H. P.A. Hyattsville, Md.						JUL 23 1982			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 9 0 0 6

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HENRIETTA F COOKE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>07 21 82</b>			2b. HOUR <b>10:00A.M.</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 30 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.				
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md.</b>			13b. COUNTY <b>A. A.</b>		13c. CITY OR TOWN <b>Lothian</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>320 Kevins Court</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Paul Ambach</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna ?</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>085-32-4586</b>		17. INFORMANT ADDRESS <b>Above Florence Estes, Daughter, Same as</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Pneumonia &amp; C.H.F.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Widespread Metastatic Ca</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immed.</b> <b>3 wks</b> <b>8 yrs</b>								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>U.T.I., Cerebral Metastasis, A.S.H.P.</b>		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>7/21/82</b> to <b>7/21/82</b> that (I) (we) last saw the deceased alive on <b>7/21/82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.										
22b. SIGNATURE <b>Kevin Brincher</b>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>7/21/82</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K.L. MINCHIN</b>			22e. ADDRESS <b>6188 OXON HILL RD OXON HILL MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7-23-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, P.G., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Robt E Wilhelm</b>			ADDRESS <b>4308 Suitland Rd., Suitland, Md.</b>		25. DATE RECEIVED BY REGISTRAR <b>JUL 27 1982</b>		26. REGISTRAR'S SIGNATURE <b>James J. Hadden</b>			

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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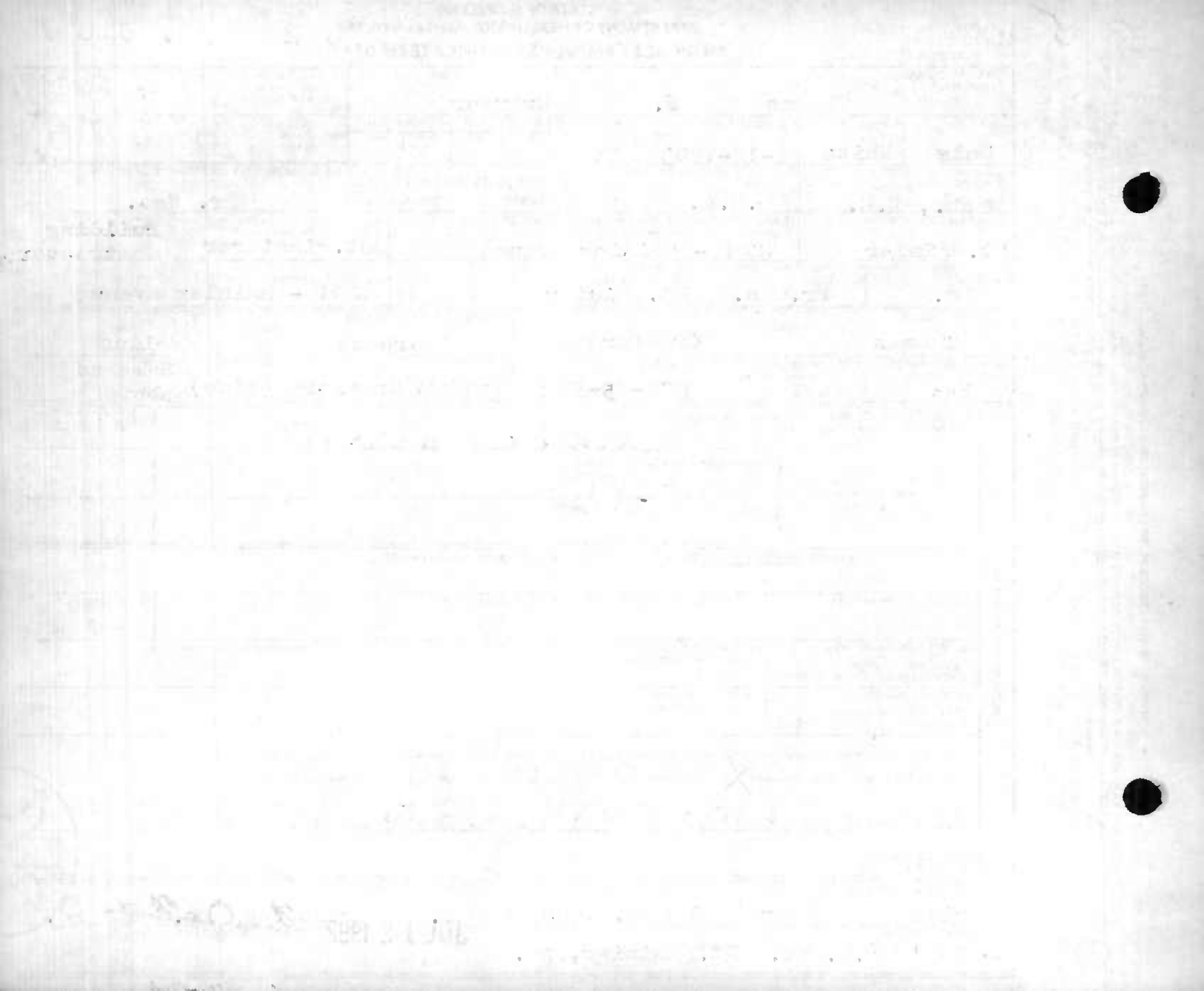


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8219007											
1. FOR STATE REGISTRAR						2a. DATE KNOWN OF DEATH						MONTH DAY YEAR		7 4 82		2b. HOUR		7:30 A.M.			
1. DECEASED NAME (TYPE OR PRINT)						FIRST MIDDLE LAST						Thomas F. Crawford									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		7 4 82		2d. HOUR		7:30 P.M.	
Male		White		3-12-1903		79 YRS.															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH									
Wash... D.C.				U.S.A.								Pr. Geo. MD.									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS					
Mt. Rainier				4201 - Rainier Avenue								Ret. Plasterer				Building Contractor					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Md.		Pr. Geo.		Mt. Rainier		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4201 - Rainier Avenue													
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST						FIRST MIDDLE LAST															
Thomas Crawford						Florence Bellus															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS									
Yes				WWI				579-05-5239				Evelyn Crawford (Wife)				Same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																					
PART I DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>																					
DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																					
(b) <u>ASVD</u>																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?							
														YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
				HOUR A.M. MONTH DAY YEAR																	
				P.M. 19																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION													
								STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED													
SAID A. J. DARR M				Deputy				7-4-82													
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				23e. REGISTRAR'S SIGNATURE					
Burial				7-6-82				Ft. Lincoln Cem				Brentwood, Md.									
24. FUNERAL DIRECTOR				25. REGISTRAR'S SIGNATURE																	
NAME				ADDRESS																	
Nalley's F.H. Inc.				Mt. Rainier, Md.																	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. IF DEATH OCCURS WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1- STATE REGISTRAR										8 2 1 9 0 0 8	
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH	
FIRST MIDDLE LAST <b>WALTER HOWELL CURTIS, Jr.</b>										MONTH DAY YEAR <b>7 27 82</b>	
3. SEX 4. RACE 5. DATE OF BIRTH 6. AGE (IN YEARS) IF UNDER 1 YR. IF UNDER 24 HRS.										2c. DATE PRONOUNCED DEAD	
Male White Jan. 18, 1934 48 YRS. MONTHS DAYS HOURS MIN.										MONTH DAY YEAR <b>7 - 27 82</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH	
Washington D.C. U.S.A.										Prince Georges	
10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK) 12b. KIND OF BUSINESS OR INDUSTRY	
Laurel Greater-Laurel Beltsville Hospital										Vice Principal High School	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS										8703 Graystone Lane	
14. FATHER'S NAME 15. MOTHER'S MAIDEN NAME											
Walter H. Curtis, Sr. Delores Pennyfield Denny											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE DATES) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS										17. INFORMANT ADDRESS	
Yes OR UNKNOWN Korean 213 38 0104 Delores E. Curtis Same as #13 (Wife)											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4408 IMMEDIATE CAUSE (a) Cardiac arrest											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.											
(b) ASVD											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>Said A. Daece</b> TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER DATE SIGNED <b>7-28-82</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>Said A. Daece, M.D.</b> ADDRESS <b>5632 Annapolis Rd Bladensburg, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>7/30/82</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Maryland</b>											
24. FUNERAL DIRECTOR'S NAME <b>Francis Gasch's Sons Funeral Home, P.A.</b> 25a. DATE REC'D. BY REGISTRAR <b>JUL 30 1982</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>											
26. HYATTSVILLE, MARYLAND											

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Washington D.C.

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### Implications

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 9 0 0 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MAK N DAVIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7 27 82</b>			2b. HOUR <b>7 56</b> <sup>56</sup> / <sub>4</sub> <sup>M</sup>					
3. SEX <b>MALE</b>		4. RACE <b>N</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 30 92</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.					
10. CITY OR TOWN OF DEATH <b>Forrestville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Agency Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cook (Retired)</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>D. C.</b> 13b. COUNTY <b>Washington</b> 13c. CITY OR TOWN <b>Washington</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS <b>1518 Caroline Street, N. W.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Davis</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Not Stated</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW I</b>		17. INFORMANT ADDRESS <b>Washington, D.C.</b> <b>Norman W. Bland, Friend, 1501 Caroline St, NW</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: <b>4960</b> IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>C.O.P.D. from Breunhardt</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Multiple Myeloma, Cerebral atrophy</b>											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERSTANDING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>7/27/82</b> to <b>7/27/82</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death)											
22b. SIGNATURE <b>John L. Minchin M.D.</b>			22c. DEGREE <b>M.D.</b>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <b>7/27/82</b>		
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. L. MINCHIN M.D.</b>			22g. ADDRESS <b>6188 OXON HILL RD OXON HILL MD</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2 Aug 82</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memo Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Landover, P. G. Co., Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>W. Ernest Jarvis Co., Inc.,</b>			ADDRESS <b>Washington, D.C.</b>			25a. DATE REC'D. BY REGISTRAR <b>AUG 5 1982</b>			25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies (Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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THE FOLLOWING INFORMATION IS FOR THE USE OF THE

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS ANTICIPATED. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19010	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHY CATHERINE DAY										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR X 7-10 82	
3. SEX FEMALE 4. RACE WHITE 5. DATE OF BIRTH MONTH DAY YEAR 6-7-24 58 YRS. 6. AGE (IN YEARS LAST BIRTHDAY) 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.										2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7-10 19 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.										7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES	
10. CITY OR TOWN OF DEATH Baltimore - Hillcrest Hts.										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3001 Branch Avenue, Apt. 818	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Key Punch										12b. KIND OF BUSINESS OR INDUSTRY Riggs Nat'l. Bank	
13a. STATE Md. 13b. COUNTY Pr. Geo. 13c. CITY OR TOWN Hillcrest Hts.										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Michael J. Sweeney										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irene B. Payne	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No										16b. SOCIAL SECURITY NO. 577-18-2711	
17. INFORMANT Gary W. Day (Son)										17b. ADDRESS 14258-Evans Trail Beltsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: HYPERTENSIVE CARDIOVASCULAR DISEASE 4029 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER										DATE SIGNED 7-10-82	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D. ADDRESS 5009 Rayburn Ct., Temple Hills, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 7-14-82	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.										23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.	
24. FUNERAL DIRECTOR NAME Nailey's F.H. Inc. ADDRESS Mt. Rainier, Md.										25a. DATE REC'D. BY REGISTRAR JUL 19 1982	



*Handwritten signature*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 should be filed within 72 hours after death. The medical examiner must be notified of the death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE	LAST		
KENNETH		DILLARD		07 21 82		3:21A, M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH	
Male	Black	Feb 2, 1902		80 YRS.		Prince Georges MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
D. C.	USA			Prince Georges		Clinton	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS	
Southern Maryland Hospital		Disable Vet.		None		1118 4th Street, N.E.	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
D. C.		Washington	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1118 4th Street, N.E.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
Sam Dillard		Hattie Unknown		Yes			
16b. SOCIAL SECURITY NO.		17. INFORMANT		17. ADDRESS			
579-09-5707		Mrs. Celeste H. Dillard/wife/same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:							
5860 IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>							
DUE TO, OR AS A CONSEQUENCE OF							
(b) <i>Septicemia</i>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <i>Renal failure</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.							
<i>old cerebrovascular accident</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>2/21/82</i> to <i>2/21/82</i> , that (I) (we) last saw the deceased alive on <i>2/21/82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
<i>Massoud N. M.D.</i>		M.D.				7.21.82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR			
Massoud N. M.D.		3611 Branch Ave. Marlow Heights, Md. 20748		JUL 29 1982			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. NAME OF CEMETERY OR CREMATORY		23c. LOCATION		23d. DATE OF DEATH	
Burial		Ft. Lincoln		Brentwood Md.		7-24-82	
24. FUNERAL DIRECTOR							
John T. Rhines Co., 3015 12th St., N.E.D.C. 20017							

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19012	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Gary Loren Dilley						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7 6 19 82		2b. HOUR 10 P M			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 6 DAY 5 YEAR 58	6. AGE (IN YEARS LAST BIRTHDAY) 24 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 7 6 19 82		2d. HOUR 10 P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Utah		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD					
10. CITY OR TOWN OF DEATH Suitland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3904 Walnut Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Manager		12b. KIND OF BUSINESS OR INDUSTRY Auto			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY PG		13c. CITY OR TOWN Suitland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3904 Walnut Lane			
14. FATHER'S NAME FIRST MIDDLE LAST Gerald Dilley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret O'Neill							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 508-78-0943		17. INFORMANT ADDRESS Holechek F. H., Oshkosh, Neb.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head (rifle)</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last. 9552										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? xx 7 6 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self inflicted					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3904 Walnut Lane Suitland P.G. MD.					
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Virginia L. Dolan</u>				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER DATE SIGNED 7/7/82			
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS III Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 7-10-82		23c. NAME OF CEMETERY OR CREMATORY Ash Hollow Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Lewellen, Garden, Neb.			
24. FUNERAL DIRECTOR NAME Robt E Wilhelm 4308 SUITLAND Rd., Suitland, Md.						25a. DATE REC'D. BY REGISTRAR JUL 14 1982					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession of this certificate is required for the removal of the body from the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1 DECEASED NAME (TYPE OR PRINT)		2a DATE OF DEATH				2b HOUR			
FIRST MARY		MIDDLE Magdaline				LAST Dillon			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR	
Female		White		Jan 13 1904		78 YRS.		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		U.S.A.				Prince Georges MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR	
Lanham, Md.		Magnolia Gardens Nursing Home				Saleslady		+ 30throy	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS	
Maryland		Prince Geo.		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		600 39th Place	
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST James		MIDDLE		LAST Lynch		FIRST Sally		MIDDLE	
								LAST Shelton	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
No		579-34-3025		Lawrence E. Gray		4511 Wicomico Ave Beltsville, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Myocardial infarction									
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease									
DUE TO, OR AS A CONSEQUENCE OF (c) Aneurysm									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from June 16, 1982, to July 10, 1982, that (I) (we) lost saw the deceased alive on July 10, 1982, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not see the body after death.									
22b. SIGNATURE		DEGREE				COVERING ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
James J. Kim, M.D.								7-10-82.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
JAMES J. KIM		10694 CAMPUS WAY S. LARGO, MD. 20772							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		7/13/82		Ft. Lincoln Cemetery		Brentwood P.G. Maryland			
24 FUNERAL DIRECTOR'S NAME ADDRESS									
Frank Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland									





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19014	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MELANIE A. DiMEGO						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7-6-82 19		2b. HOUR M			
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 11 1949 32 YRS.	6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 7-6-82 19		2d. HOUR 8AM		M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.					
10. CITY OR TOWN OF DEATH Largo		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN A FACILITY, GIVE STREET ADDRESS) 1026 Butterworth Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY PG		13c. CITY OR TOWN Largo		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1026 Butterworth Lane			
14. FATHER'S NAME FIRST MIDDLE LAST Donald Ailes				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lily Thorz				ADDRESS Same as Above			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 171-40-1236		17. INFORMANT Geoffrey DiMego, Husband							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 1991 IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margie Beck			TITLE (SPECIFY) M. Assistant					DATE SIGNED 7-6-82			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.			ADDRESS 111 Penn Street								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-8-82		23c. NAME OF CEMETERY OR CREMATORY Wash. Natl. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Maryland				
24. FUNERAL DIRECTOR NAME Robt E Wilhelm 4308 Suitland Rd., Suitland, Md.						25a. DATE REC'D. BY REGISTRAR JUL 14 1982		25b. REGISTRAR'S SIGNATURE James O. ...			



RECEIVED NOTICE

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 9 0 1 5  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LENA L. DOMRAS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7 3 82</b>			2b. HOUR <b>7:20</b> P. M.		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 10, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS. MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.		
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Hyattsville Manor Care</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Wheaton</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>12705 Bushey Drive</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>August Husner</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma SAUTER</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-20-3183</b>		17. INFORMANT ADDRESS <b>Philip C. Domras Son Same as 13</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY <b>4292</b> IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4 YEARS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>CEREBROVASCULAR INSUFFICIENCY</b>								
19a. DATE OF OPERATION <b>N.A.</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N.A.</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from <b>MAY 19 78</b> to <b>7/31 19 82</b> , that (I) (we) lost saw the deceased alive on <b>7/21 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Dennis J. Hand MD</b> DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>7/3/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DENNIS J. HAND MD</b>				22e. ADDRESS <b>4600 CONNECTICUT AVE N.W. WASHINGTON DC</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 7, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Virginia</b>		
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b> ADDRESS <b>500 University Boulevard, W. Silver Spring, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 8 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Van Natten</b>		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before the body is released.

XXXX SATUR

10-25-58

Item 11 per phone 8/4/82 dad  
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 19016

1. DECEASED NAME (TYPE OR PRINT)		FIRST GRACE		MIDDLE M.		LAST DORSEY		20. DATE KNOWN OF DEATH ESTIMATED		MONTH 7		DAY 24		YEAR 82		21. HOUR 1235 AM	
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 3 15 44		6. AGE (IN YEARS) LAST BIRTHDAY 38 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		22. DATE PRONOUNCED DEAD		MONTH DAY YEAR 7 24 82		23. HOUR 1235 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.											
10. CITY OR TOWN OF DEATH LAUREL		11. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) CITY OR TOWN MONTG. Silver Spring										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Land Hospital		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3118 Fairland Rd.									
14. FATHER'S NAME FIRST MIDDLE LAST HERBERT JACKSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GRACE ADAMS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO													
16b. SOCIAL SECURITY NO. 213-46-8843		17. INFORMANT ADDRESS Marcus Dorsey (husband) same as #13															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Carcinoma of the lung DUE TO, OR AS A CONSEQUENCE OF (c) With metastasis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE SAUNDERS A. DARE MD Deputy										TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) ADDRESS																	
23a. BURIAL, CREMATION, REMOVAL TYPE BURIAL				23b. DATE 7-28-82				23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN				23d. LOCATION CITY OR TOWN COUNTY Silver Spring Montg. Md.					
24. FUNERAL DIRECTOR NAME George R. Snowden ADDRESS 246 N. Wash. St. Rockville, MD. DATE REC'D. BY REGISTRAR JUL 28 1982																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.





FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 9 0 1 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SHIRLEY MARIE DOWNS.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7-24-1982</b>			2b. HOUR <b>530 P.M.</b>				
3. SEX <b>Female</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2-22-1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>St. Marys Co. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE MD.</b>				
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Clinton Convalescent Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Fed. Gov't.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fed. Gov't.</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>					13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Hillcrest Hts.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES H. READMOND</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BESSIE S. JARBOE</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>577-54-1160</b>		17. INFORMANT ADDRESS <b>BERNARD C. DOWNS AS IN ITEM 13A</b>			
18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4140</b> IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Arterio-sclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>6/30</b> 19 <b>82</b> to <b>7/24</b> 19 <b>82</b> that (I) <del>lost</del> lost saw the deceased alive on <b>7/23</b> 19 <b>82</b> and that (my) <del>best</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> did not view the body after death.										
22b. SIGNATURE <b>R. M. ...</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/24/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>REZA MUSTAFA</b>						22e. ADDRESS <b>4235 28th Ave Md 20031</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7/27/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Pr. Geo Maryland</b>			
24. FUNERAL DIRECTOR'S NAME <b>Shirley Philips</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 29 1982</b>		25b. GISTER'S SIGNATURE <b>Shirley Philips</b>		

25  
30  
33  
160  
1

MEDICAL CERTIFICATION

2  
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



57

Journal 7/27/82 Cedar Hill Cemetery Highland Pr. Geo. Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP \_\_\_\_\_  
DHMM - 16 50M 1/BI  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) DONALD LEWIS DURGEE					2a. DATE OF DEATH MONTH DAY YEAR JULY 7, 1982			2b. HOUR 12:30p <sup>M</sup>	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 6, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 57		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH ANDREWS AFB		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND					13c. CITY OR TOWN CAMP SPRINGS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST CLYDE PUTNAM DURGEE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORIS LUELLA DELANO				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1942-1961		17. INFORMANT ADDRESS MD DOROTHY DURGEE 4705 PELHAM CRT, CAMP SPRINGS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION:		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL 20</u> 19 <u>82</u> to <u>JULY 7</u> 19 <u>82</u> that (I) (we) last saw the deceased alive on <u>APRIL 20</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) open the body after death.									
22b. SIGNATURE <u>Paul Salbert</u> DEGREE					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED JULY 7, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL SALBERT, CAPT, USAF, MC					22e. ADDRESS MALCOLM GROW USAF MC, AAFB, MD 20331				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/12/82		23c. NAME OF CEMETERY OR CREMATORY Cheltenham Md. Vet. Cheltenham P.G.		23d. LOCATION CITY OR TOWN COUNTY STATE Md.		23e. DATE REC'D. BY REGISTRAR (25) REGISTRAR'S SIGNATURE JUL 15 1982 <u>James J. Nathan</u>	
24. FUNERAL DIRECTOR Lee Funeral Home 6633 Old Alexander Ferry Rd. Clinton Md.									

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.



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UNITED STATES DEPARTMENT OF AGRICULTURE  
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WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 9 0 1 9			
FOR 1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MABEL B. DUTY				2a. DATE OF DEATH MONTH DAY YEAR 07-25-82		2b. HOUR 3:42AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb 7 1924		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Food Manager		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. STATE Maryland				13b. COUNTY Calvert		13c. CITY OR TOWN Owings	
14. FATHER'S NAME FIRST MIDDLE LAST Isreal Boldwin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Miller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) 2 No				16b. SOCIAL SECURITY NO. 232-40-8262		17. INFORMANT ADDRESS Charles E Duty Sr. Co. #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 0389 IMMEDIATE CAUSE (a) Cardiac pulmonary arrest. DUE TO, OR AS A CONSEQUENCE OF b) advanced cardiac disease DUE TO, OR AS A CONSEQUENCE OF c) Septicemia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Renal failure. Arterovenous fistula bleeding. Bleeding diathesis.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 7, 1982, to July 25, 1982, that (I) (we) lost the deceased alive on July 24, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Rishpal Singh				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-25-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RISHPAL SINGH				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE July 28, 82		23c. NAME OF CEMETERY OR CREMATORY Southern Memorial Garden		23d. LOCATION CITY OR TOWN COUNTY STATE Dunk Green Md	
24. FUNERAL DIRECTOR NAME Rausch Funeral Home				25. DATE REC'D. BY REGISTRAR JUL 30 1982			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 2 1 9 0 2 0				
CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>John H Dyer</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>7-3-82</b>			2b. HOUR <b>6:45 A M</b>	
3. SEX <b>M</b>		4. RACE <b>N</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>February 25-89</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRI NCE GEORGES MD</b>			
10. CITY OR TOWN OF DEATH <b>Capitol Heights</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Regency N-H.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>unk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>unk</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>PRINCE GEORGES</b>		13c. CITY OR TOWN <b>Wash., D.C.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1515 C St., S.E.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>unknown</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Henrietta Dyer</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>579 60 8721</b>		17. INFORMANT ADDRESS <b>Ruth Giles 1515 C St., S.E. Wash., D.C.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Anterior Cerebral Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immed.</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>SP Intertracheal Fx L Rib Blindness &amp; Chronic Brain Injury</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>April 1982 to July 3rd 1982</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>April 1982 to July 3rd 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>Kelvin L. Minchin</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>7/3/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KELVIN L. MINCHIN</b>					22e. ADDRESS <b>6188 OXON HILL RD OXON HILL MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>7/09/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>ALEXANDER S. POPE-2617 Pa Ave., S.E. Wash., DC</b>					25. DATE REC'D BY REGISTRAR <b>JUL 12 1982</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 9 0 2 1	
1 - FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>DANIEL E. EARNER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7-26-82</b>		2b. HOUR <b>6:50 AM</b>
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 16 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>CLINTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE, GIVE FACILITY AND STREET ADDRESS) <b>SOUTHERN MARYLAND HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Gas Co.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>WGL Co.</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>Maryland Prince George Forest Heights</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>9 Tecumseh Dr.</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Patrick J. Earner</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marion K. White</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-07-9278</b>		17. INFORMANT ADDRESS <b>James R. Earner 1213 Lindsay Rd. Oxon Hill, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b> <b>5990</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>URINARY TRACT INFECTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (c) _____ DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>3 DAYS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>7-25-82</b> to <b>7-26-82</b> , that (I) (we) lost saw the deceased alive on <b>7/25-19-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>om-nedz</b>		DEGREE		22c. DATE SIGNED <b>7-26-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT M. NEDZBALA</b>		22e. ADDRESS <b>9401 INDIAN HEAD HIGHWAY, OXON HILL, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/29/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>		23e. DATE REC'D. BY REGISTRAR <b>JUL 29 1982</b>			
24. FUNERAL DIRECTOR NAME <b>George P. Kalas Funeral Home</b>		24b. ADDRESS <b>6160 Oxon Hill Rd. Oxon Hill, Md.</b>			

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Male	Caucasian	June 16 1903	79
Washington, D.C. U.S.A.	x		
		Pet. Can Co.	Pat. Co.
Maryland	Prince George's Forest Heights	x	9 Leominster
Patrick	J.	Farmer	Marion
No	517-07-9278	James E. Farmer	1213 Lindey Rd. Oxon Hill, Maryland
			White

George E. Kales Funeral Home  
 6150 Oxon Hill Rd.  
 Oxon Hill, Md.  
 St. Mary's Cemetery  
 Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the report of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 9 0 2 2	
1 - FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				REG. NO.	
LUEGINIA C. EDWARDS				2a. DATE OF DEATH MONTH DAY YEAR 07-29-82	
3 SEX Female				2b. HOUR 9:04AM	
4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12/29/1932		6 AGE (IN YEARS LAST BIRTHDAY) 49 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC		7b CITIZEN OF WHAT COUNTRY? USA		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR NOW OR WORKING LIFE) Housewife	
13a. STATE MD		13b. COUNTY PG County		13c. CITY OR TOWN Hysville	
14. FATHER'S NAME FIRST MIDDLE LAST Willie F Gaddy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie V Edwards		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 240 46 5493		17. INFORMANT ADDRESS Hystville Maryland Irben J Edwards, Jr 5342 Chespeak, rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> 3352 DUE TO, OR AS A CONSEQUENCE OF (b) <u>PULMONARY CONGESTION DUE TO</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>AMYOTROPHIC LATERAL SCLEROSIS</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>MOTOR NEURONE DISEASE, HYPERPARATHYROIDISM</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/20/1982</u> to <u>7/29/1982</u> , that (I) (we) lost saw the deceased alive on <u>7/28/1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>K. Mohan</u>		DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. MOHAN M.D.		22e. ADDRESS 6492 LANDOVER RD, #C, LANDOVER, MD. 20785			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/3/82		23c. NAME OF CEMETERY OR CREMATORY Washington Natl	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland		23e. DATE REC'D. BY REGISTRAR AUG 5 1982			
24. FUNERAL DIRECTOR NAME Dudley, S Fun Home Inc. 1425 M		24b. ADDRESS Wash DC			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										19023	
FOR 1- STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>James Clifford ELLERHORST</b>							2a. DATE KNOWN OF DEATH		2b. DATE OF DEATH		
3. SEX <b>M</b>							4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>Sept.</b> DAY <b>26</b> YEAR <b>1914</b>		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>INDIANA</b>							7. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. CITY OR TOWN OF DEATH <b>COLLEGE PARK</b>							10. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6030 Westchester Park Dr. APT #201</b>		11. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PRINTER (Retired)</b>		
12. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>PRINCE GEORGE</b> 13c. CITY OR TOWN <b>College Park</b>							13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6030 Westchester Park Dr. APT #201</b>		
14. FATHER'S NAME FIRST <b>CLIFFORD</b> MIDDLE <b>FREDERICK</b> LAST <b>ELLERHORST</b>							15. MOTHER'S MAIDEN NAME FIRST <b>NINA</b> MIDDLE <b>E.</b> LAST <b>F.</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>							16b. SOCIAL SECURITY NO. <b>315-07-4128</b>		17. INFORMANT ADDRESS <b>BETTY A. ELLERHORST SAME AS 13A-E</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>hx of cirrhosis of liver</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>SAID A. DAEE MD</b>			TITLE (SPECIFY) <b>Deputy</b>			MEDICAL EXAMINER		DATE SIGNED <b>7-20-82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>SAID A. DAEE</b>			ADDRESS _____								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>7/21/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>METROPOLITAN CREMATORY</b>			23d. LOCATION CITY OR TOWN <b>ALEXANDRIA</b> COUNTY <b>—</b> STATE <b>VIRGINIA</b>				
24. FUNERAL DIRECTOR NAME <b>CHARLES F. BELL JR.</b>			ADDRESS <b>POB 119, PRINCE FRED, MD</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 21 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Charles F. Bell Jr.</b>			

COLTON INDEX

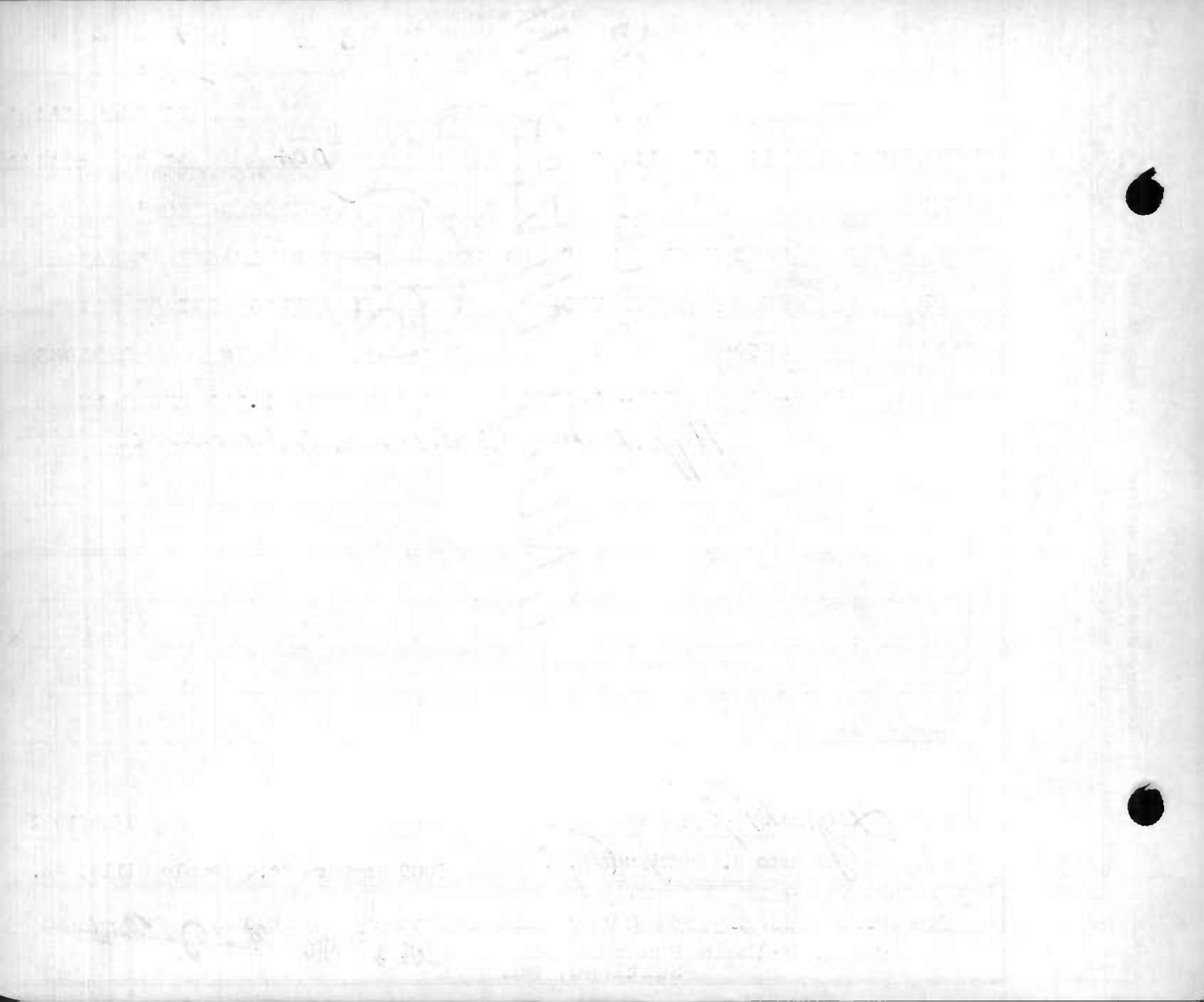


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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19024	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>BETTY R. ELLIOTT</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN <b>07 24 19 82 14M</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>CAU</b>		5. DATE OF BIRTH MONTH <b>11</b> DAY <b>30</b> YEAR <b>11</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MICHIGAN</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S</b> MD.	
10. CITY OR TOWN OF DEATH <b>ANDREWS AFB</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MALCOM GROW USAF MED CEN</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>OFFICE MANAGER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MD</b>		13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>OXON HILL</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>524 WILSON BRIDGE DRIVE</b>			
14. FATHER'S NAME FIRST <b>NELSON</b> MIDDLE <b>OSGOOD</b> LAST <b>RHOADES</b>						15. MOTHER'S MAIDEN NAME FIRST <b>FRANCES</b> MIDDLE <b>BROWN</b> LAST <b>RHOADES</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>1944-45</b>		17. INFORMANT <b>MARSHA DONNELLY</b>		ADDRESS <b>FT WASH MD 13323 QUEEN LN</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4029 Hypertensive (cardiovascular) disease</b> IMMEDIATE CAUSE (a) <b>4029</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION _____											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____											
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b> M.D.						TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER		DATE SIGNED <b>7/24/1982</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez M.D.</b>						ADDRESS <b>5009 Rayburn Ct., Temple Hills, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>25 July 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>				23d. LOCATION CITY OR TOWN <b>Suitland</b> COUNTY <b>PO</b> STATE <b>Md</b>	
24. FUNERAL DIRECTOR NAME <b>Robert E. Wilhelm</b>						ADDRESS <b>Funeral Home Suitland, Md.</b>		25. DATE REC'D. BY REGISTRAR <b>JUL 30 1982</b>			

BP

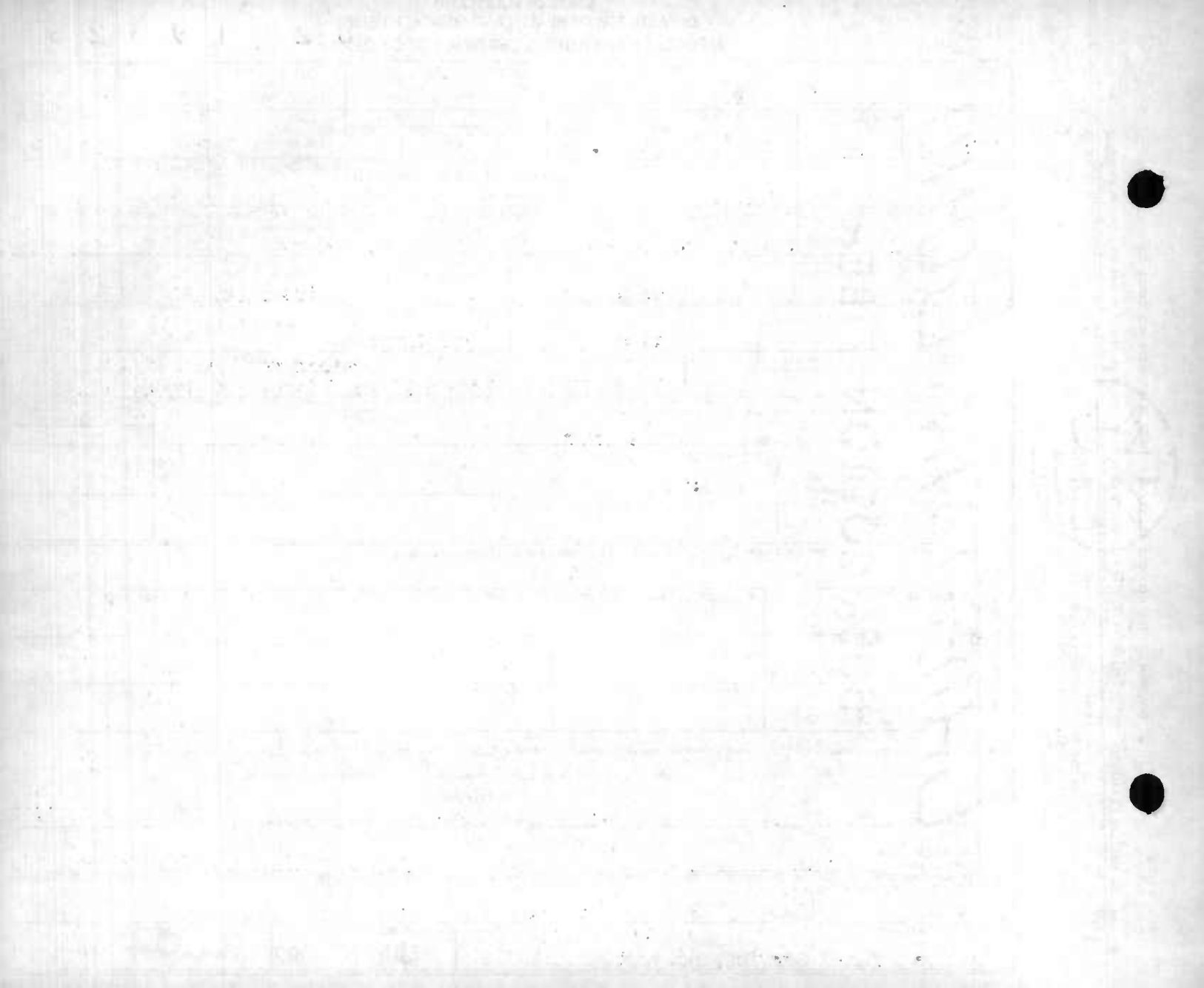




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BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8219025																													
1. DECEASED NAME (TYPE OR PRINT) <b>Blanche P. Elliott</b>										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>July 4 1982</b>										2b. HOUR <b>2 P M</b>																													
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>Apr.</b> DAY <b>12,</b> YEAR <b>1898</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>84</b> YRS.		IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD <b>July 4 1982</b>										2d. HOUR <b>8 P M</b>																											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD.																																					
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Grooms Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>District Thtr.</b>																																					
13a. STATE <b>D.C.</b>										13b. COUNTY <b>Washington</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS <b>654 Girard St. NW, # 201</b>																			
14. FATHER'S NAME FIRST <b>Isum</b> MIDDLE <b>Price</b> LAST <b>Price</b>										15. MOTHER'S MAIDEN NAME FIRST <b>Ida</b> MIDDLE <b>Grayson</b> LAST <b>Grayson</b>										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>										16b. SOCIAL SECURITY NO. <b>579-03-1680 A</b>										17. INFORMANT <b>Washington, D.C. 20020</b> <b>Alfreda Pitts, friend, 2637 Naylor Rd. SE</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4408</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>ASVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>																													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																																																	
ACTUAL SIGNATURE <b>Said A. Daee</b>										TITLE (SPECIFY) <b>Deputy</b>										DATE SIGNED <b>July 4, 1982</b>																													
EXAMINER'S NAME (TYPE OR PRINT) <b>Said A. Daee, M. D.</b>										ADDRESS <b>5632 Annapolis Rd., Bladensburg, Md.</b>																																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>										23b. DATE <b>July 6, 1982</b>										23c. NAME OF CEMETERY OR CREMATORY <b>Lee and Sons' Crematory</b>										23d. LOCATION CITY OR TOWN <b>Washington, D.C.</b> COUNTY STATE																			
24. FUNERAL DIRECTOR NAME <b>McGuire Funeral Service, Inc.</b>										ADDRESS <b>Wash, D.C. 20012</b>										DATE REC'D. BY REGISTRAR <b>JUL 9 1982</b>										25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>																			



item 7a G570 8/31/82 ph

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 9 0 2 6  
CERTIFICATE OF DEATH

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
**WILLIAM ELLIS**

2a. DATE OF DEATH MONTH DAY YEAR  
**07-25-82**

2b. HOUR  
**9:03PM**

3. SEX  
**MALE**

4. RACE  
**BLACK**

5. DATE OF BIRTH MONTH DAY YEAR  
**2 24 1913**

6. AGE (IN YEARS LAST BIRTHDAY) YRS  
**69**

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
**N.C.**

7b. CITIZEN OF WHAT COUNTRY?  
**U.S.A.**

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
**PRINCE GEORGE'S COUNTY MD.**

10. CITY OR TOWN OF DEATH  
**CHEVERLY**

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
**PRINCE GEORGE'S GENERAL HOSP.**

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
**RETIRED**

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS  
**MD PRINCE GEORGE SEAT Pleasant YES X NO 1211 DUNBAR DRIVE**

14. FATHER'S NAME FIRST MIDDLE LAST  
**WILLIS ELLIS**

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
**MARY ELLIS**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME UNKNOWN) (IF YES, GIVE WAR OR DATES)  
**NO**

16b. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
**YU ANITA McKNIGHT 1211 Dunbar**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  
**1629 IMMEDIATE CAUSE (a) METASTATIC CARCINOMA**  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  
(b) **LUNG CANCER (EPIDERMAL)**  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  
**HYPERCALCEMIA**

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
**P.M. 19**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

21g. I certify that (1) this hospital attended the deceased from **7/25** 19 **82** to **7/25** 19 **82**, that (1) (we) last saw the deceased alive on **7/25** 19 **82**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we last did not view the body after death.)

22a. SIGNATURE  
**P. SCHLOSSER MD**

DEGREE **MD**

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED  
**7/26/82**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
**P. SCHLOSSER MD**

22e. ADDRESS  
**7500 GREENWAY CRT DR. GREENBELT MD 20770**

23a. BURIAL, CREMATION, REMOVAL  
**BURIAL**

23b. DATE  
**July 30 1982**

23c. NAME OF CEMETERY OR CREMATORY  
**MARYLAND NATIONAL**

23d. LOCATION CITY OR TOWN COUNTY STATE  
**CARVAC MD**

24. FUNERAL DIRECTOR NAME ADDRESS  
**W. H. BACON 3427 14th Ave**

25a. DATE REC'D. BY REGISTRAR  
**JUL 28 1982**

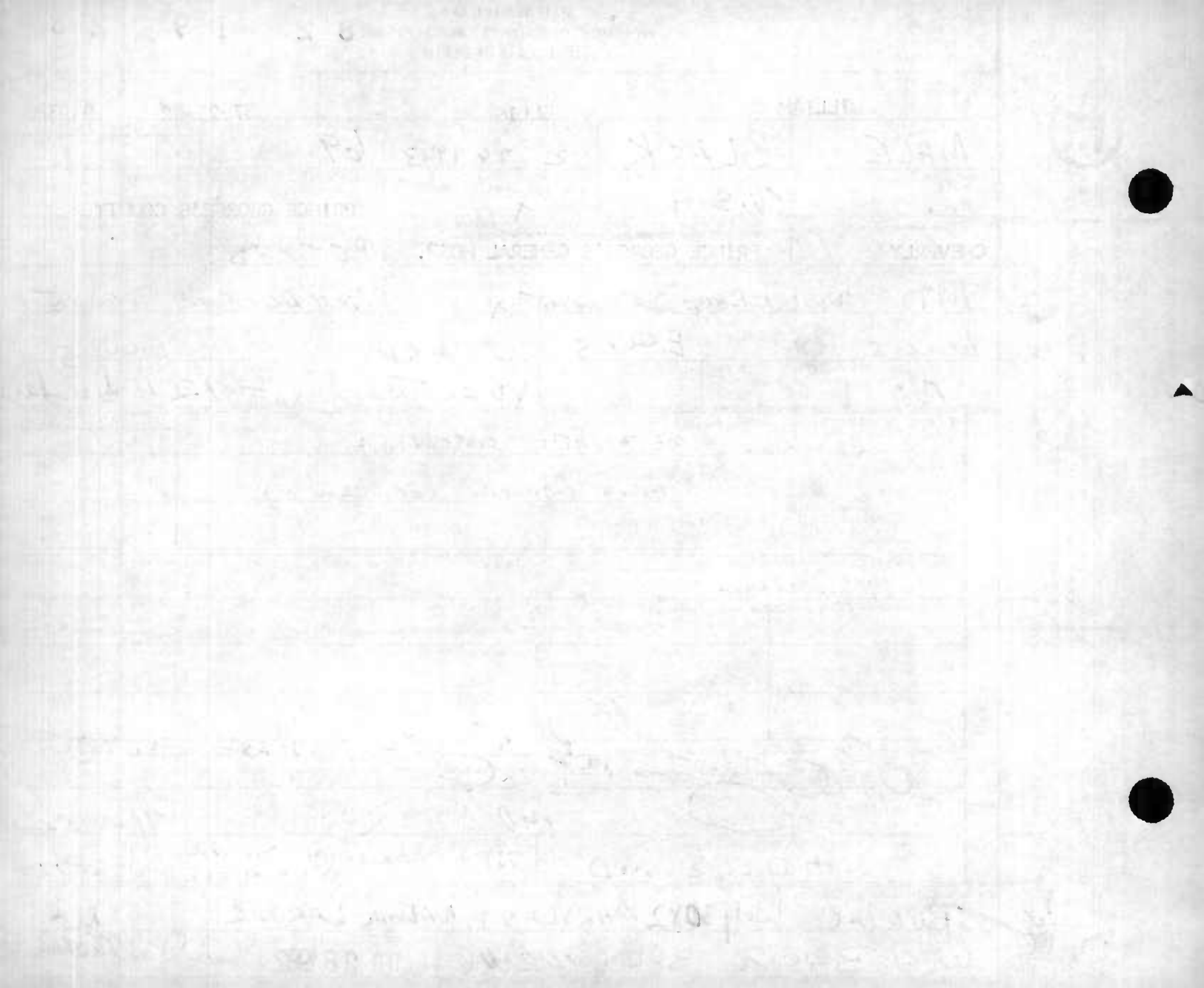
25b. REGISTRAR'S SIGNATURE  
**Frances VanNathan**

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



BP \_\_\_\_\_

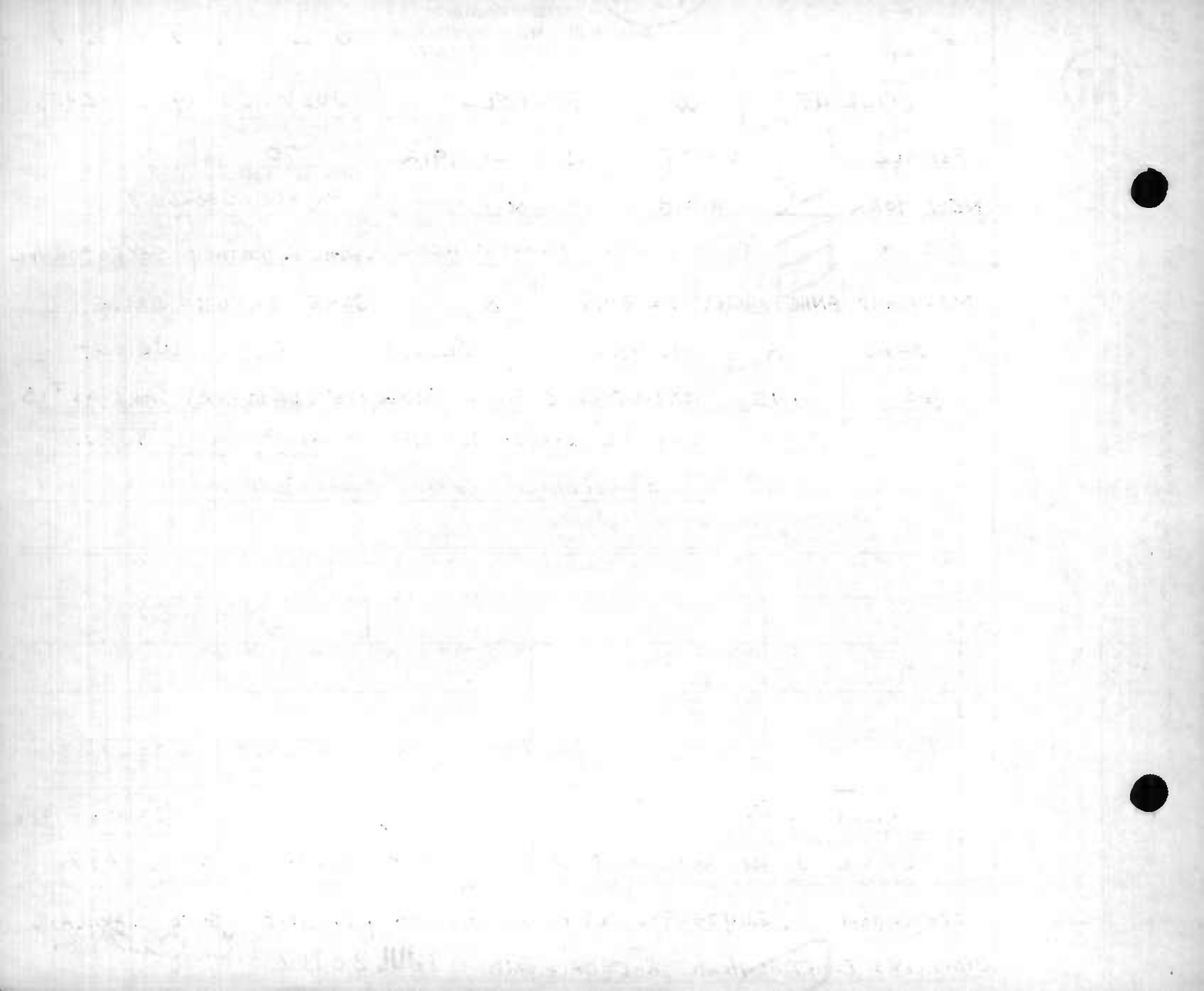
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 9 0 2 7	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>OLLINE W. FARRELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 23 1982</b>		2b. HOUR <b>4:45 A.M.</b>
3 SEX <b>FEMALE</b>	4 RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 21, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S</b> MD.			10. CITY OR TOWN OF DEATH <b>ADELPHI</b>		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PAINT BRANCH NURSING HOME</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LEGAL SECRETARY</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>SECRETARIAT</b>			13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13b. STREET ADDRESS <b>8245 LEXINGTON DRIVE</b>			14. FATHER'S NAME FIRST MIDDLE LAST <b>DAVID A. Mc GILL</b>		
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>OLLINE E. WRIGHT</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		
16b. SOCIAL SECURITY NO. <b>089-07-0018</b>			17. INFORMANT ADDRESS <b>OLLINE PADGETTE (DAUGHTER) SAME AS #13.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>CARDIAC ARREST SECONDARY TO ARRHYTHMIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>UNKNOWN</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>STREET</b>			
21f. LOCATION CITY OR TOWN COUNTY STATE <b>RIVERDALE M.D. 20737</b>		22a. I certify that (I) (this hospital) attended the deceased from <b>22 JAN. 1980</b> to <b>23 JULY 1982</b> , that (I) (we) lost saw the deceased alive on <b>23 JULY 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Carl J. Houmann</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>23 JULY 1982</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CARL J. HOUMANN M.D.</b>		22e. ADDRESS <b>RIVERDALE M.D. 20737</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>JULY 24, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CREMATORY SUITLAND, P.G. CO. MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>CHAMBERS FUNERAL HOME RIVERDALE, MD.</b>		24b. DATE REC'D. BY REGISTRAR <b>JUL 28 1982</b>		24c. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

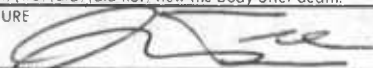

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>RUBY FRANCES FENWICK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 13 1982</b>		2b. HOUR <b>4:25 p.m.</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10-29-1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.	
10. CITY OR TOWN OF DEATH <b>Lanham</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Doctors' Hospital of Pr. Geo. Co.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. U.S. Gov't.</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Worker</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Md.</b>	13b. COUNTY <b>Pr. Geo.</b>	13c. CITY OR TOWN <b>Hy.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>2322 - Woodberry St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Calhoun Barbour</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Zella A. Brown</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No -</b>		16b. SOCIAL SECURITY NO. <b>217-52-6536</b>	17. INFORMANT ADDRESS <b>Same as Charlotte Garvin (Niece) above</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> 2859 DUE TO, OR AS A CONSEQUENCE OF (b) <b>RENAL FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ANGINA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6-29-82</b> to <b>7-13-82</b> , that (I) (we) lost the deceased on <b>7-13-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE		22c. DATE SIGNED <b>7/14/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Hong L. Tee, M.D.</b>		22e. ADDRESS <b>3415 Hamilton St., Hyattsville, Md. 20782</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-17-82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Pr. Geo. Md.</b>
24. FUNERAL DIRECTOR NAME <b>Nalley's F.H. Inc. Mt. Rainier, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 20 1982</b>		
25b. REGISTRAR'S SIGNATURE 					

MEDICAL CERTIFICATION

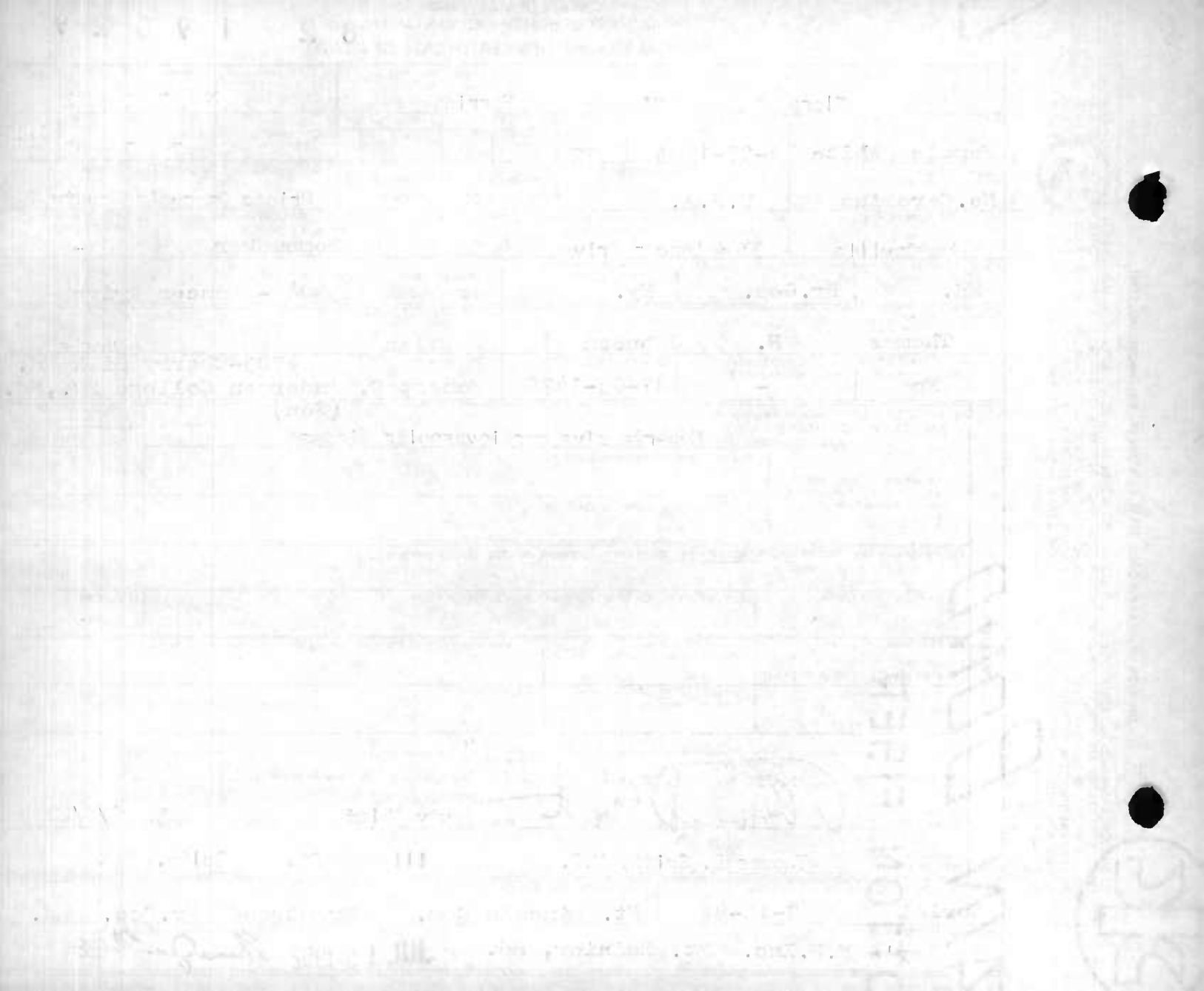


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19029	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Flora E. Ferrina										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7 2 19 82	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2-27-1905		6. AGE (IN YEARS) LAST BIRTHDAY 77 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 7 19 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) No. Carolina				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD	
10. CITY OR TOWN OF DEATH Hyattsville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3304 Lancer Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY -	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.										13b. CITY OR TOWN Pr. Geo.	
13c. CITY OR TOWN Hy.										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 3304 - Lancer Drive											
14. FATHER'S NAME FIRST MIDDLE LAST Thomas H. Johnson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Davis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 247-05-1478					
17. INFORMANT Robert C. Anderson						4709 Cherry Hill Rd. College Pk., Md. (Son)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 7/8/82			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St.				Balto., MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7-12-82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.			
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc.						ADDRESS Mt. Rainier, Md.		25a. DATE REC'D. BY REGISTRAR JUL 15 1982		25b. REGISTRAR'S SIGNATURE <i>Thomas D. Smith</i>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 17 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

2

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

19030

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTI- MATED <input type="checkbox"/>			MONTH DAY YEAR			7b. HOUR M			
TRISTIN ELIZABETH FERRO									7-26-82			11:16P			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) (LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			
Female		Caucasian		Feb. 22, 1982		YRS. 5						7-26-82, M			
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland				U.S.A.								Prince George's County MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Clinton				Souther Maryland Hospital				n/a				n/a			
13a. STATE				13b. CITY OR TOWN				13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13d. STREET ADDRESS			
Maryland				Pr. George's				Upper Marlboro				9536 Montrose Street			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Philip Anthony Ferro				Victoria Rugani											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS							
no				n/a				216-98-5103 Philip Ferro - Same As #13 A-E							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital heart abnormality and Downs syndrome 7459 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER								DATE 7-27-82 SIGNED			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Margarita A. Koroll, M.D.				111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				July 29, 1982				Resurrection Cemetery				Clinton Pr. George's MD			
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.								25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
16633 Old Alexander Ferry Road, Clinton, Maryland								AUG - 5 1982				John J. Caniff			

1205

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2

UNITED STATES

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	1	9	0	3	1
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH						
FIRST MIDDLE LAST <i>Thomas F. Ferry, Jr.</i>										MONTH DAY YEAR <i>July 8, 1982</i>						
3 SEX										2b. HOUR						
Male										<i>10:30 P.M.</i>						
4 RACE										5. DATE OF BIRTH						
White										MONTH DAY YEAR <i>Sept. 15, 1902</i>						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										6 AGE (IN YEARS LAST BIRTHDAY)						
Washington, D.C.										79 YRS.						
7b. CITIZEN OF WHAT COUNTRY?										9 BALTIMORE CITY OR COUNTY OF DEATH						
U.S.A.										Prince George MD.						
10. CITY OR TOWN OF DEATH										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						
Hyattsville										Principal						
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12b. KIND OF BUSINESS OR INDUSTRY						
Carroll Manor Nursing Home										D.C. Pub. Sch.						
13a. STATE										13b. STREET ADDRESS						
---										4509 Warren Street, N.W.						
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST <i>Frank Ferry</i>										FIRST MIDDLE LAST <i>Agnes Rover</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										17. INFORMANT ADDRESS						
no										Son - James Branson Ferry - Same as #13						
16b. SOCIAL SECURITY NO.										17. INFORMANT ADDRESS						
---										577-18-4646						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY:																
4850 IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>										2 days						
DUE TO, OR AS A CONSEQUENCE OF																
(b) <i>Brachypharyngitis</i>										4 days						
DUE TO, OR AS A CONSEQUENCE OF																
(c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
<i>PARKINSON'S Disease</i>																
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						
20a. AUTOPSY?										20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY						
										HOUR A.M. MONTH DAY YEAR P.M. 19						
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)						
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK										21f. LOCATION						
										STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>7/6/82</i> , 19____, to <i>7/8/82</i> , 19____, that (I) (we) lost saw the deceased alive on <i>7/8/82</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED						
22b. SIGNATURE										22d. ADDRESS						
<i>James J. Foster M.D.</i>										916 - 19th St., N.W., Wash. D.C.						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS						
James J. Foster, M.D.										916 - 19th St., N.W., Wash. D.C.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE						
Burial										July 12, 1982						
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION						
Gate of Heaven Cem.										Silver Spring, Md.						
24. FUNERAL DIRECTOR										25. DATE REC'D. BY REGISTRAR						
<i>James E. B...</i>										JUL 12 1982						
NAME ADDRESS Washington, D.C.																



2

• • •

27

• • •

1000 2000 3000

2000 2001 2002 2003

Page 2014

1227 e. H. H. 100 2702 - 100 100

• D. C. •

DATE OF DEATH: 10-10-1944

Items #18a-22a Film G570 8/30/82  
 FOR  
 1- STATE  
 REGISTRAR  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 7 31 82  
 2b. HOUR 6:40 AM

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Barbara D. Foster  
 3. SEX Female 4. RACE Black 5. DATE OF BIRTH MONTH DAY YEAR Jan. 5, 1932 50 YRS.  
 6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.  
 7c. DATE PRONOUNCED DEAD 7 31 19 82 2d. HOUR 6:40 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina 7b. CITIZEN OF WHAT COUNTRY? USA  
 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐  
 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD  
 10. CITY OR TOWN OF DEATH Cheverly 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital  
 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife 12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE Maryland 13b. COUNTY F.G. 13c. CITY OR TOWN  
 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ 13e. STREET ADDRESS 723 Captiol Hgts., Blvd.

14. FATHER'S NAME FIRST MIDDLE LAST Marion Dawkins  
 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fletie Smith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no (IF YES, GIVE WAR OR DATES)  
 16b. SOCIAL SECURITY NO. 251 50 9168  
 17. INFORMANT ADDRESS Michael M. Foster-son 723 Capitol Hgts., Blvd., Capitol Hgts., Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid & Intracerebral Hemorrhage  
 4300  
 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  
 (b) DUE TO, OR AS A CONSEQUENCE OF  
 (c) DUE TO, OR AS A CONSEQUENCE OF  
 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  
 20. AUTOPSY? YES ☒ NO ☐

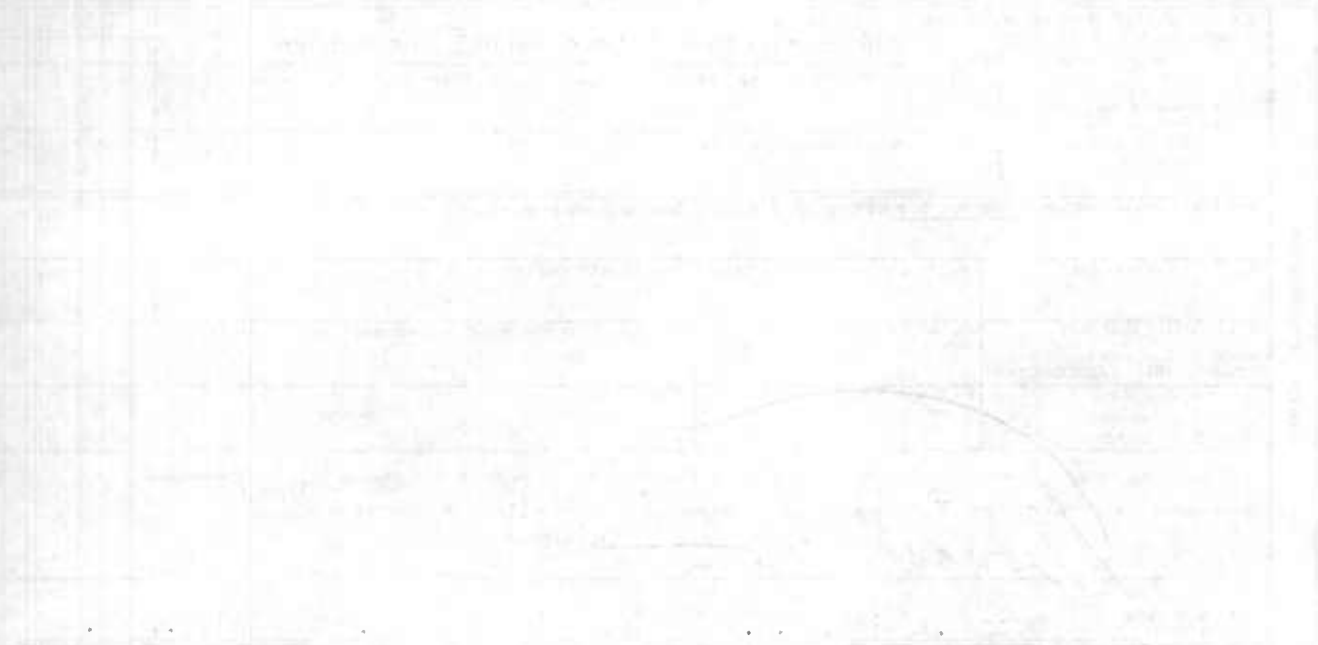
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH  
 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  
 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  
 21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK  
 21e. PLACE OF INJURY (STREET, FACTORY, FARM, ETC.)  
 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐  
 Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion  
 ACTUAL SIGNATURE Thomas D. Smith, M.D. TITLE (SPECIFY) Deputy Chief MEDICAL EXAMINER  
 EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. ADDRESS 111 Penn St. Balto., MD.  
 DATE SIGNED 8/2/82

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE Aug. 5, 1982  
 23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park-Landover, Maryland  
 23d. LOCATION CITY OR TOWN COUNTY STATE  
 24. FUNERAL DIRECTOR NAME Stewart Funeral Home 4001 Benning Rd., N.AUG 9 1982  
 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Section 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



The above diagram is a representation of the structure of the dome, showing the internal divisions and the curvature of the surface. It is intended to illustrate the principles of geometry and the construction of the dome.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Based on my belief, I am signing this certificate. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										7. DATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES CLAYTON FOSTER</b>										MONTH DAY YEAR <b>07 14 82</b>	
2. SEX <b>MALE</b>										2b. HOUR <b>0400 A.M.</b>	
3. RACE <b>BLACK</b>										4. AGE (IN YEARS LAST BIRTHDAY) <b>49</b> YRS.	
5. DATE OF BIRTH MONTH DAY YEAR <b>12 16 32</b>										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>SOUTH CAROLINA</b>										7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>LAUREL</b>										11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER LAUREL NURSING HOME</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>										13b. COUNTY <b>P.G. CO.</b>	
13c. CITY OR TOWN <b>LAUREL</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>9113 CONTEE RD. #11</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>(UNKNOWN)</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LOUISE - FOSTER</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>										16b. SOCIAL SECURITY NO. <b>KOREAN 251-46-2066A</b>	
17. INFORMANT ADDRESS <b>MOZELL FOSTER (WIFE) SAME AS #13</b>											
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>41149</b> IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PROBABLE CORONARY ARTERY DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DIABETES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <b>3/15</b> , 19 <b>82</b> , to <b>4/14/82</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>7/5</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we (I) did not view the body after death, so state.)											
22b. SIGNATURE <b>Gregory A. Compton</b> MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22c. DATE SIGNED <b>4/14/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GREGORY A COMPTON</b>										22e. ADDRESS <b>14201 LAUREL PARK DR. LAUREL, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>										23b. DATE <b>JULY 16, 1982</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CREMATORY</b>										23d. LOCATION CITY OR TOWN COUNTY STATE <b>BURITLAND, P.G. CO. MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>CHAMBERS FUNERAL HOME</b>										25a. DATE REC'D. BY REGISTRAR <b>JUL 21 1982</b>	
ADDRESS <b>RIVERDALE, MD.</b>											

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CARDINAL ORDER

REPUBLICAN PARTY

Div 1112

11/25/50

11/25/50

Chicago A. C. C. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 9 0 3 4			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MARY MIDDLE FRISSORA LAST				MONTH DAY YEAR HOUR P M			
				07 23 82 7:21 P M			
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		CAUCASIAN		MONTH DAY YEAR		87 XXXX	
				OCT 12, 1894		YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
CZECHOSLOVAKIA		U.S.A.				PRINCE GEORGE'S COUNTY MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CHEVERLY		NURSING CARE CENTER PRI.GEO.HOSP.		HOUSEWIFE			
13a. STATE				13b. COUNTY			
MARYLAND				PRI. GEORGES			
13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
BELTSVILLE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS				13f. STREET ADDRESS			
12500 OLD GUN POWDER ROAD 2070							
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST PETER KOMAN				FIRST MIDDLE LAST ANNA MOROZ			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
NO				175-12-5326			
17. INFORMANT				ADDRESS			
MARY FRISSORA DAUGHTER SAME AS 13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) 4860 CARDIOPULMONARY ARREST							
DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA AND PROBABLE SEPSIS							
DUE TO, OR AS A CONSEQUENCE OF (c) HISTORY OF RECURRENT PNEUMONIA WITH EFFUSION							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
CELLULITIS LEFT FOOT. @ DEHYDRATION.							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			
				P.M. 19			
21a. INJURY OCCURRED				21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>				21c. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/9/82, 19 to 7/23, 1982, that (I) (we) last saw the deceased alive on 7/23, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				22c. DATE SIGNED			
22b. SIGNATURE				22d. ADDRESS			
Samuel Alleyne				PRINCE GEORGES HOSPITAL CHEVERLY, MARYLAND			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)				22f. DATE SIGNED			
SAMUEL ALLEYNE, M.D.				7/24/82			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE			
BURIAL				7/26/82			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
RESURRECTION CEMETERY				CITY OR TOWN COUNTY STATE			
CORAOPOLIS ALLEGHENY PA							
24 FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR			
FRANCIS J. COLLINS				AUG-4 1982			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25b. REGISTRAR'S SIGNATURE			
				Francis J. Collins			

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1901-1902



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 9 0 3 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
BLANCHE H GARNER				MONTH DAY YEAR 07-15-82			
1. SEX				2b. HOUR			
FEMALE				1:02A.M.			
4. RACE				6. AGE (IN YEARS LAST BIRTHDAY)			
WHITE				80 YRS.			
5. DATE OF BIRTH				7. BALTIMORE CITY OR COUNTY OF DEATH			
MONTH DAY YEAR JAN. 2, 1902				Prince Georges MD.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
MARYLAND				9. BALTIMORE CITY OR COUNTY OF DEATH			
7b. CITIZEN OF WHAT COUNTRY?				10. CITY OR TOWN OF DEATH			
U. S. A.				Clinton			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Southern Maryland Hospital Center				HOUSEWIFE			
12b. KIND OF BUSINESS OR INDUSTRY				OWN HOME			
13a. STATE				13b. CITY OR TOWN			
MARYLAND				PR. GEO'S UPPER MARLBORO			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST SAMUEL P. HOOK				FIRST MIDDLE LAST ANNIE -- DULEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
NO				--			
17. INFORMANT				ADDRESS			
THOS. JAMES GARNER				11411 CROOM RD., UPPER MARLBORO, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC HEART DISEASE				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:				OBSTRUCTIVE LUNG DISEASE			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				21d. LOCATION CITY OR TOWN COUNTY STATE			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-14-82 to 7-15-82, that (I) (we) lost saw the deceased alive on 7-14-82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				22c. DATE SIGNED 7-15-82			
22b. SIGNATURE Danilo Lee, M.D.				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Danilo Lee, M.D.				6192 Oxon Hill Rd., Oxon Hill, Md. 20745			
23a. BURIAL, CREMATION, REMOVAL				23b. DATE			
BURIAL				7/17/82			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
ST. THOMAS CEMETERY				CROOM (PR. GEO'S) MD.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR			
RICHARD A. COLEMAN-UPPER MARLBORO, MARYLAND 20772				AUG - 5 1982			
25b. REGISTRAR'S SIGNATURE				25c. REGISTRAR'S SIGNATURE			
				John J. Lewis			



FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Nelson GARNER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 21, 1982</b>		2b. HOUR <b>4:45 a.m.</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>April 28 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kansas</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.			
10. CITY OR TOWN OF DEATH <b>Lanham</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Doctors' Hospital of Pr. Geo. Co.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>US Gov</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>machinist</b>	
13a. STATE <b>Mid</b>			13b. CITY OR TOWN <b>Belvert Chesapeake Bay</b>		13c. STREET ADDRESS <b>3505 Bayview Drive</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Guy N Garner</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gertrude Greeson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1WWT 57216 6874</b>		17. INFORMANT ADDRESS <b>Ruth Garner same. 00# 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4860 Sepsis</b> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bilateral Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Chronic Renal failure, Diabetes mellitus, Cerebral Atrophy</b>						
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USEFUL IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>7-17-82</b> to <b>7-21-82</b> , that (I) (we) last saw the deceased alive on <b>7-20-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Rupert Singh</b>				DEGREE		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RISHPAL SINGH</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22e. ADDRESS <b>4700 Auth place Camp Springs Md 20023</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>July 21, 82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>PG Md</b>
24. FUNERAL DIRECTOR NAME <b>Rausch Funeral Home</b>				ADDRESS <b>Owings Md</b>		25a. DATE RECEIVED BY REGISTRAR <b>JUL 27 1982</b>
				25b. REGISTRAR'S SIGNATURE <b>James J. Nathan</b>		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19037	
1. DECEASED NAME (TYPE OR PRINT) <b>THEODORE M. GASIOR</b>										2a. DATE KNOWN OF DEATH <b>7 22 82</b>	
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>4 1 14</b>	6. AGE (IN YEARS) <b>68</b>	7. IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	8. IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD <b>7 22 82</b>		2d. HOUR <b>11:30</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b>					
10. CITY OR TOWN OF DEATH <b>Bowie</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bowie Health Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Int. Broth. of Elec.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Workers</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Bowie</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2815 Stoneybrook Dr.</b>			
14. FATHER'S NAME <b>Alexander Gasior</b>				15. MOTHER'S MAIDEN NAME <b>Josephine Stanchetz</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>273-01-4925</b>		17. INFORMANT ADDRESS <b>Eileen D. Gasior Same as #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4100 Cardiac arrest</b> IMMEDIATE CAUSE (a) <b>MI, Renal failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASVD hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>hypertension</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>SAID A. DAERF</b>				TITLE (SPECIFY) <b>Dep. M.D.</b>				DATE SIGNED <b>7-22-82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>SAID A. DAERF</b>				ADDRESS <b>5632 Annapolis Rd. Bladensburg Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-26-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery Bowie, Pr.</b>				23d. LOCATION CITY OR TOWN <b>Bowie, Pr. Georges</b>			
24. FUNERAL DIRECTOR <b>Beall Funeral Home</b>				25a. DATE OF RECORD <b>JUL 28 1982</b>				25b. REGISTRAR'S SIGNATURE			
16000 Annapolis Rd. Bowie, Md. <b>Mini</b>											

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253-01-0252

2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810 2811 2812 2813 2814 2815 2816 2817 2818

2021-10-10

3011 Forest Hill Drive

[illegible]



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH THE DEATH AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19038																			
1. DECEASED NAME (TYPE OR PRINT) Rita Elizabeth Gawen										2a. DATE KNOWN OF DEATH MONTH 7 DAY 30 YEAR 1982										2b. HOUR 9:00 P.M.																													
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 8 DAY 15 YEAR 24		6. AGE (IN YEARS) LAST BIRTHDAY 57 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH 7 DAY 30 YEAR 1982										7d. HOUR 7:00 P.M.																											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD																			
10. CITY OR TOWN OF DEATH Cheverly										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Prince George's General Hospital										12a. USUAL OCCUPATION (TYPE OF WORK OR INDUSTRY) Housewife										12b. KIND OF BUSINESS Own Home																			
13a. STATE Maryland										13b. COUNTY P.G.										13c. CITY OR TOWN Cheverly										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS 2500 Crest Avenue									
14. FATHER'S NAME FIRST MIDDLE LAST Edwin B. Wallach										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Glorius										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No										16b. SOCIAL SECURITY NO. 578 24 2073										17. INFORMANT ADDRESS Wilbur W. Gawen Same as #13 (Husband)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min.										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																													
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion										TITLE (SPECIFY) Deputy MEDICAL EXAMINER																													
ACTUAL SIGNATURE Barry M. Shmookler, MD										DATE SIGNED 7/31/82										EXAMINER'S NAME (TYPE OR PRINT) Barry M. Shmookler ADDRESS PG6H, Cheverly, Md.																													
23a. BURIAL, CREMATION, REMOVAL Burial										23b. DATE 8/3/82										23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery										23d. LOCATION Washington D.C. COUNTY STATE																			
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland										25a. DATE REC'D. BY REGISTRAR AUG 4 1982										25b. REGISTRAR'S SIGNATURE Anne J. [Signature]																													



4/15/57

Barry N. Shanker  
Barry N. Shanker  
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Hyperkalemia  
Acute myocardial infarction

Barry N. Shanker  
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Barry N. Shanker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

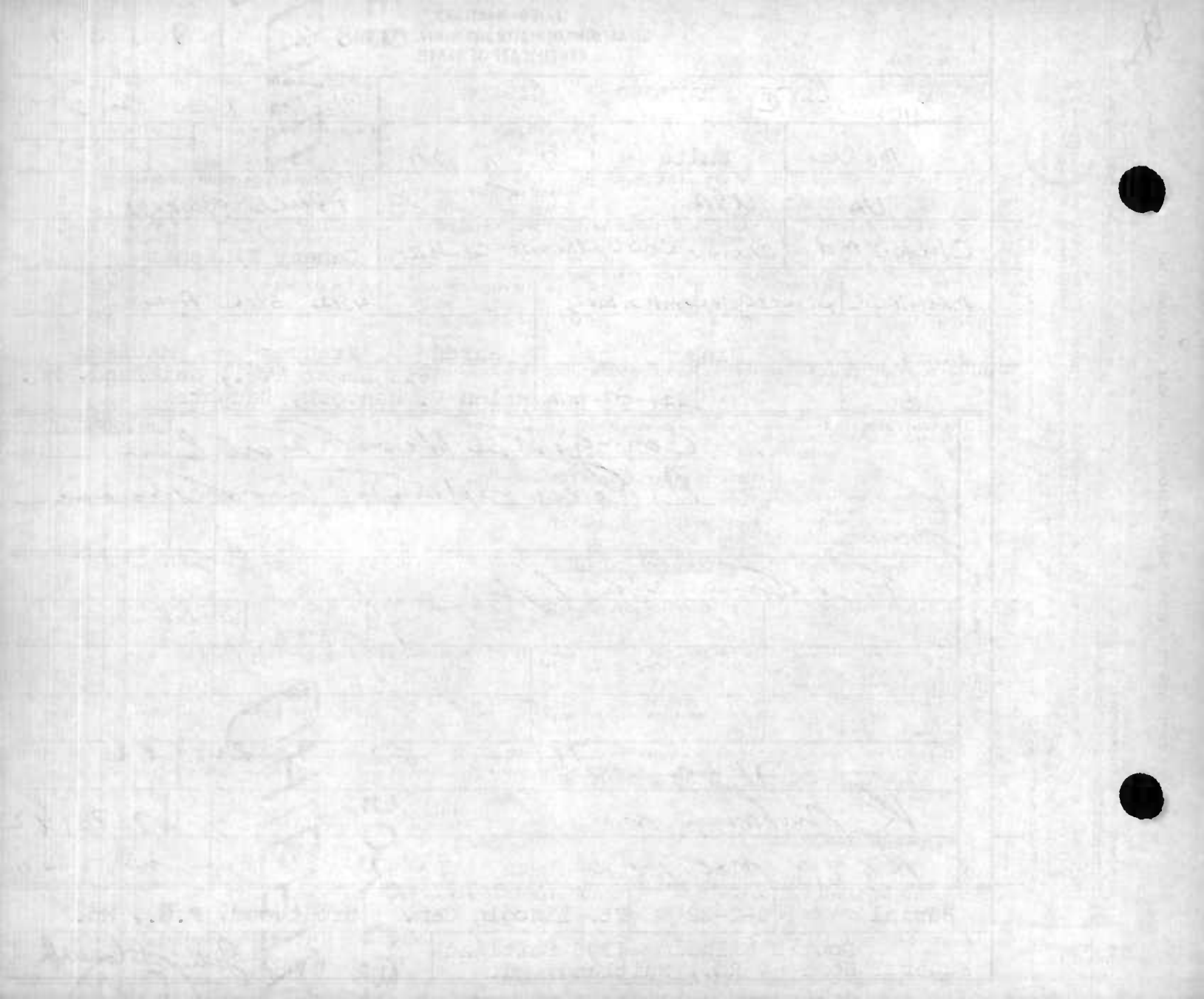
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					2. DATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT)					2. DATE OF DEATH				
CLYDE RAYMOND GIBSON					7/30/82 7 30 82 6 PM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		White		7 11 1989		93 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
VA.		USA.				PRINCE GEORGES. MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Clinton Md		Clinton Convalescent Center				Cement Finisher			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
13a. STATE 13b. COUNTY 13c. CITY OR TOWN					YES <input type="checkbox"/> NO <input type="checkbox"/>		4212 53rd Ave		
14. FATHER'S NAME (FIRST MIDDLE LAST)					15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)				
James Gibson					Sarah Frances Madison				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT					
No		229-07-1101A		4653 Lamar Ave., Suitland, Md. Helen V. Hancock, Daughter					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.									
4140 IMMEDIATE CAUSE (a) Congestive Heart Failure									
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Sclerotic Heart Disease									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Fracture of hip									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR		19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/14/82 to 7/30/82, that (I) (we) last saw the deceased alive on 7/30/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
R. Gibson MD				7/30/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
R 52A MOSTAN		4235 26th St NW 20031							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		8-2-82		Ft. Lincoln Cem.		Brentwood, P.G., Md.			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
NAME Robt E Wilhelm		4308 Suitland Rd., Suitland, Md.		AUG 9 1982 John J. Carroll					

MEDICAL CERTIFICATION

9  
9

1

4002 BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 9 0 4 0

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		LUMON T. GRAY		07 23 82		1:10A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		BLACK		AUGUST 17, 1920		61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
TENNESSEE		U.S.A.				PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CLINTON		Southern MARYLAND		WAITER		RESTAURANT	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		P.G.		CLINTON		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
LUMAN		BERNICE		10905 PENNY AVE.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
YES		410-16-8818		ODETTA COWAN, NEICE,		10905 PENNY AVE. CLINTON, MD. 20735	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a).		19. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
1991 DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) CEREBROVASCULAR ACCIDENT (c) PROBABLE METASTATIC CARCINOMA		SEPSIS		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
		21e. PLACE OF INJURY		21f. LOCATION		21g. LOCATION	
		21f. LOCATION		21g. LOCATION		21h. LOCATION	
		21g. LOCATION		21h. LOCATION		21i. LOCATION	
		21h. LOCATION		21i. LOCATION		21j. LOCATION	
		21i. LOCATION		21j. LOCATION		21k. LOCATION	
		21j. LOCATION		21k. LOCATION		21l. LOCATION	
		21k. LOCATION		21l. LOCATION		21m. LOCATION	
		21l. LOCATION		21m. LOCATION		21n. LOCATION	
		21m. LOCATION		21n. LOCATION		21o. LOCATION	
		21n. LOCATION		21o. LOCATION		21p. LOCATION	
		21o. LOCATION		21p. LOCATION		21q. LOCATION	
		21p. LOCATION		21q. LOCATION		21r. LOCATION	
		21q. LOCATION		21r. LOCATION		21s. LOCATION	
		21r. LOCATION		21s. LOCATION		21t. LOCATION	
		21s. LOCATION		21t. LOCATION		21u. LOCATION	
		21t. LOCATION		21u. LOCATION		21v. LOCATION	
		21u. LOCATION		21v. LOCATION		21w. LOCATION	
		21v. LOCATION		21w. LOCATION		21x. LOCATION	
		21w. LOCATION		21x. LOCATION		21y. LOCATION	
		21x. LOCATION		21y. LOCATION		21z. LOCATION	
		21y. LOCATION		21z. LOCATION		21aa. LOCATION	
		21z. LOCATION		21aa. LOCATION		21ab. LOCATION	
		21aa. LOCATION		21ab. LOCATION		21ac. LOCATION	
		21ab. LOCATION		21ac. LOCATION		21ad. LOCATION	
		21ac. LOCATION		21ad. LOCATION		21ae. LOCATION	
		21ad. LOCATION		21ae. LOCATION		21af. LOCATION	
		21ae. LOCATION		21af. LOCATION		21ag. LOCATION	
		21af. LOCATION		21ag. LOCATION		21ah. LOCATION	
		21ag. LOCATION		21ah. LOCATION		21ai. LOCATION	
		21ah. LOCATION		21ai. LOCATION		21aj. LOCATION	
		21ai. LOCATION		21aj. LOCATION		21ak. LOCATION	
		21aj. LOCATION		21ak. LOCATION		21al. LOCATION	
		21ak. LOCATION		21al. LOCATION		21am. LOCATION	
		21al. LOCATION		21am. LOCATION		21an. LOCATION	
		21am. LOCATION		21an. LOCATION		21ao. LOCATION	
		21an. LOCATION		21ao. LOCATION		21ap. LOCATION	
		21ao. LOCATION		21ap. LOCATION		21aq. LOCATION	
		21ap. LOCATION		21aq. LOCATION		21ar. LOCATION	
		21aq. LOCATION		21ar. LOCATION		21as. LOCATION	
		21ar. LOCATION		21as. LOCATION		21at. LOCATION	
		21as. LOCATION		21at. LOCATION		21au. LOCATION	
		21at. LOCATION		21au. LOCATION		21av. LOCATION	
		21au. LOCATION		21av. LOCATION		21aw. LOCATION	
		21av. LOCATION		21aw. LOCATION		21ax. LOCATION	
		21aw. LOCATION		21ax. LOCATION		21ay. LOCATION	
		21ax. LOCATION		21ay. LOCATION		21az. LOCATION	
		21ay. LOCATION		21az. LOCATION		21ba. LOCATION	
		21az. LOCATION		21ba. LOCATION		21bb. LOCATION	
		21ba. LOCATION		21bb. LOCATION		21bc. LOCATION	
		21bb. LOCATION		21bc. LOCATION		21bd. LOCATION	
		21bc. LOCATION		21bd. LOCATION		21be. LOCATION	
		21bd. LOCATION		21be. LOCATION		21bf. LOCATION	
		21be. LOCATION		21bf. LOCATION		21bg. LOCATION	
		21bf. LOCATION		21bg. LOCATION		21bh. LOCATION	
		21bg. LOCATION		21bh. LOCATION		21bi. LOCATION	
		21bh. LOCATION		21bi. LOCATION		21bj. LOCATION	
		21bi. LOCATION		21bj. LOCATION		21bk. LOCATION	
		21bj. LOCATION		21bk. LOCATION		21bl. LOCATION	
		21bk. LOCATION		21bl. LOCATION		21bm. LOCATION	
		21bl. LOCATION		21bm. LOCATION		21bn. LOCATION	
		21bm. LOCATION		21bn. LOCATION		21bo. LOCATION	
		21bn. LOCATION		21bo. LOCATION		21bp. LOCATION	
		21bo. LOCATION		21bp. LOCATION		21bq. LOCATION	
		21bp. LOCATION		21bq. LOCATION		21br. LOCATION	
		21bq. LOCATION		21br. LOCATION		21bs. LOCATION	
		21br. LOCATION		21bs. LOCATION		21bt. LOCATION	
		21bs. LOCATION		21bt. LOCATION		21bu. LOCATION	
		21bt. LOCATION		21bu. LOCATION		21bv. LOCATION	
		21bu. LOCATION		21bv. LOCATION		21bw. LOCATION	
		21bv. LOCATION		21bw. LOCATION		21bx. LOCATION	
		21bw. LOCATION		21bx. LOCATION		21by. LOCATION	
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		21by. LOCATION		21bz. LOCATION		21ca. LOCATION	
		21bz. LOCATION		21ca. LOCATION		21cb. LOCATION	
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		21cb. LOCATION		21cc. LOCATION		21cd. LOCATION	
		21cc. LOCATION		21cd. LOCATION		21ce. LOCATION	
		21cd. LOCATION		21ce. LOCATION		21cf. LOCATION	
		21ce. LOCATION		21cf. LOCATION		21cg. LOCATION	
		21cf. LOCATION		21cg. LOCATION		21ch. LOCATION	
		21cg. LOCATION		21ch. LOCATION		21ci. LOCATION	
		21ch. LOCATION		21ci. LOCATION		21cj. LOCATION	
		21ci. LOCATION		21cj. LOCATION		21ck. LOCATION	
		21cj. LOCATION		21ck. LOCATION		21cl. LOCATION	
		21ck. LOCATION		21cl. LOCATION		21cm. LOCATION	
		21cl. LOCATION		21cm. LOCATION		21cn. LOCATION	
		21cm. LOCATION		21cn. LOCATION		21co. LOCATION	
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		21co. LOCATION		21cp. LOCATION		21cq. LOCATION	
		21cp. LOCATION		21cq. LOCATION		21cr. LOCATION	
		21cq. LOCATION		21cr. LOCATION		21cs. LOCATION	
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		21cs. LOCATION		21ct. LOCATION		21cu. LOCATION	
		21ct. LOCATION		21cu. LOCATION		21cv. LOCATION	
		21cu. LOCATION		21cv. LOCATION		21cw. LOCATION	
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		21cw. LOCATION		21cx. LOCATION		21cy. LOCATION	
		21cx. LOCATION		21cy. LOCATION		21cz. LOCATION	
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		21dg. LOCATION		21dh. LOCATION		21di. LOCATION	
		21dh. LOCATION		21di. LOCATION		21dj. LOCATION	
		21di. LOCATION		21dj. LOCATION		21dk. LOCATION	
		21dj. LOCATION		21dk. LOCATION		21dl. LOCATION	
		21dk. LOCATION		21dl. LOCATION		21dm. LOCATION	
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		21et. LOCATION		21eu. LOCATION		21ev. LOCATION	
		21eu. LOCATION		21ev. LOCATION		21ew. LOCATION	
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		21fh. LOCATION		21fi. LOCATION		21fj. LOCATION	
		21fi. LOCATION		21fj. LOCATION		21fk. LOCATION	
		21fj. LOCATION		21fk. LOCATION		21fl. LOCATION	
		21fk. LOCATION		21fl. LOCATION		21fm. LOCATION	
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		21fm. LOCATION		21fn. LOCATION		21fo. LOCATION	
		21fn. LOCATION		21fo. LOCATION		21fp. LOCATION	
		21fo. LOCATION		21fp. LOCATION		21fq. LOCATION	
		21fp. LOCATION		21fq. LOCATION		21fr. LOCATION	
		21fq. LOCATION		21fr. LOCATION		21fs. LOCATION	
		21fr. LOCATION		21fs. LOCATION		21ft. LOCATION	
		21fs. LOCATION		21ft. LOCATION		21fu. LOCATION	
		21ft. LOCATION		21fu. LOCATION		21fv. LOCATION	
		21fu. LOCATION		21fv. LOCATION		21fw. LOCATION	
		21fv. LOCATION		21fw. LOCATION		21fx. LOCATION	
		21fw. LOCATION		21fx. LOCATION		21fy. LOCATION	
		21fx. LOCATION		21fy. LOCATION		21fz. LOCATION	
		21fy. LOCATION		21fz. LOCATION		21ga. LOCATION	
		21fz. LOCATION		21ga. LOCATION		21gb. LOCATION	
		21ga. LOCATION		21gb. LOCATION		21gc. LOCATION	
		21gb. LOCATION		21gc. LOCATION		21gd. LOCATION	
		21gc. LOCATION		21gd. LOCATION		21ge. LOCATION	
		21gd. LOCATION					



*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]*

*[Handwritten notes and markings, including a large 'X' and some illegible text.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 2 1 9 0 4 1				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
Richard H. GRAY					July 5, 1982				
3 SEX					7b. HOUR				
Male					11:50a				
4 RACE					5 DATE OF BIRTH				
Black					Dec 28, 1908				
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					6. AGE (IN YEARS LAST BIRTHDAY)				
North Carolina					73 YRS.				
7b. CITIZEN OF WHAT COUNTRY?					8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
United States					9 BALTIMORE CITY OR COUNTY OF DEATH				
Lanham					Prince George's County, MD.				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				
Doctors' Hospital of P.G. County					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
13a. STATE					13b. KIND OF BUSINESS OR INDUSTRY				
Maryland					Automotive				
13b. COUNTY					13c. CITY OR TOWN				
P.G.					Suitland				
14 FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Dave Gray					Alice Cherry				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.				
unk					578 14 2917A				
17. INFORMANT					ADDRESS				
Daughter					Md.				
Barbara Greer - 4303 Skyline Drive Suitland									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Sepsis</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal failure</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic heart disease with old myocardial infarction</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus, GI bleeding</u>									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
YES <input type="checkbox"/> NO <input type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>March 27</u> , 19 <u>82</u> , to <u>July 5</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>7/5</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Thomas Y. Ko</u>					22c. DATE SIGNED <u>7/6/82</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Thomas Y. Ko					8118 Good Luck Road, Lanham, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE				
Burial					7/10/82				
23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION CITY OR TOWN COUNTY STATE				
Harmony Memorial Park					Landover, PG Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D. BY REGISTRAR				
ALEXANDER S. POPE 2617 Pa Avenue, S.E. D.C.					JUL 9 1982				

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Black 20, 2008

United States

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19042	
1. FOR STATE REGISTRAR Item 21a&21f Item 570 8-13-82 cm											
1. DECEASED NAME (TYPE OR PRINT) Thomas L. Gray						2b. DATE KNOWN OF DEATH X MONTH 7 DAY 24 YEAR 1982		7b. HOUR 10:15 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 8 DAY 15 YEAR 1965		6. AGE (IN YEARS) LAST BIRTHDAY 16 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH 7 DAY 24 YEAR 1982	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2105 Rochelle Avenue, Apt. #2			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Lewis Gray				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janet Arnold							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. N/A		17. INFORMANT 4205 Lottsford Vista Janet Arnold Mitchellville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema 8189 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) Blunt trauma to head (c) Fall out of moving vehicle										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10.25 PM 7 18 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) trauma Fell out of Moving Vehicle & Sustained to Head					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Northview Lane & Bowie Re Bowie P.G. Md					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Myrna Rivera				TITLE (SPECIFY) Deputy				DATE SIGNED 7/26/82			
EXAMINER'S NAME (TYPE OR PRINT) Myrna Rivera, M.D.				ADDRESS Prince George's Gen. Hosp.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7-27-82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.	
24. FUNERAL DIRECTOR NAME Beall Funeral Home				ADDRESS 16,000 Annapolis Rd. Bowie, Md.				DATE RECD. BY REGISTRAR JUL 30 1982			

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(VR A15 ME (5))  
15M 2/80

July 1964 U.S.A. Prince George

Student

James Arnold Mitchell, Jr.  
1225 Locust Street  
Philadelphia, Pa.

James and  
James and  
James and

12,000 Annals of, Bowie, Md.  
Beall Funeral Home  
7-27-64 75, Lincoln Cemetery, Bethesda, Md.  
Burial

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonates. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 9 0 4 3  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>SARAH HAGOOD</b>			2a DATE OF DEATH MONTH DAY YEAR <b>07 05 82</b>		2b HOUR am <b>6:17</b>
3. SEX <b>Female</b>	4 RACE <b>Negro</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>February 14, 1907</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES COUNTY MD</b>	
10. CITY OR TOWN OF DEATH <b>CLINTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN MARYLAND HOSPITAL CENTER</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a STATE <b>Md.</b>			13b COUNTY <b>Clinton</b>	13c CITY OR TOWN <b>Clinton</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alley Patrick</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Unknown</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b SOCIAL SECURITY NO. <b>578-14-1017-D</b>		
17 INFORMANT <b>Ella B. Holt</b>			ADDRESS <b>Same as 13c.</b>		

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of gastric Contents</b> <b>2500</b>		APPROXIMATE INTERVAL BETWEEN CAUSE AND DEATH <b>20 min</b>
DUE TO, OR AS A CONSEQUENCE OF (b) _____		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Diabetes, Carcinoma of lung, Coronary artery disease</b>			
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (the hospital) attended the deceased from <b>6/3</b> , 19 <b>82</b> , to <b>7/5/82</b> , 19 <b>82</b> , that (I) <del>viewed</del> saw the deceased alive on <b>7/2</b> , 19 <b>82</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I <del>did not</del> ) (did not) view the body after death.			
22b SIGNATURE <b>Ronald Lindman MD</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED <b>7/6/82</b>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ronald Lindman MD</b>		22e ADDRESS <b>9401 Indian Head Hwy Oxon Hill, MD</b>	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b DATE <b>9 July 82</b>	23c NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Park</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>Landover Maryland</b>
24 FUNERAL DIRECTOR NAME <b>R.G. Mason Inc.</b>		25a DATE REC'D. BY REGISTRAR 25b SIGNATURE <b>JUL 12 1982</b>	
ADDRESS <b>1661 Good Hope Rd. Se.</b>			



RECEIVED  
JUL 1 1965

Handwritten signature or initials.

JUL 1 1965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of age.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 2 1 9 0 4 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WALTER E. HALL</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>07-24-82</b>		2b. HOUR <b>1:59 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 23, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S</b> MD.	
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S GENERAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Foreman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>W.S.S.C.</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Riverdale Heights</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William G. Hall</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth J. Cline</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>212-03-5427</b>		17. INFORMANT ADDRESS <b>Mrs. Helen L. Schmidt Laurel, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>acute Myocardial infarction w/ Cardiogenic Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> (AT WORK) (AT WORK)		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/23/1982</b> to <b>7/24/1982</b> , that (I) (we) lost the deceased alive on <b>7/24/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.							
22b. SIGNATURE <i>[Signature]</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/24/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PAUL A. SHAW MD</b>				22e. ADDRESS <b>Division of Cardiology-Pr. Geo. Gen. Hosp.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-27-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>George Washington Gen. H. Hattsville</b>		23d. LOCATION CITY OR TOWN <b>Hyattsville</b> STATE <b>Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>				25. JUL 28 1982			

P. Gach's Sons P. L. P. L. Hyattsville, Md.  
 George Washington Co. Hyattsville, Md.  
 7-27-22

- P. Geo. Gach, Hyattsville, Md.

(Faint, mostly illegible text in the middle section of the document)

No 212-03-5437 Mrs. Helen I. Schmidt  
 307 Carroll Ave. Laurel, Maryland  
 I. Elizabeth

Maryland P. L. Rivalda Holstak 6712 2nd Ave.

Foreman W. S. L. U.S.A. White Dec. 22, 1907 74

(Faint text at the top of the document, including a circular stamp on the right)

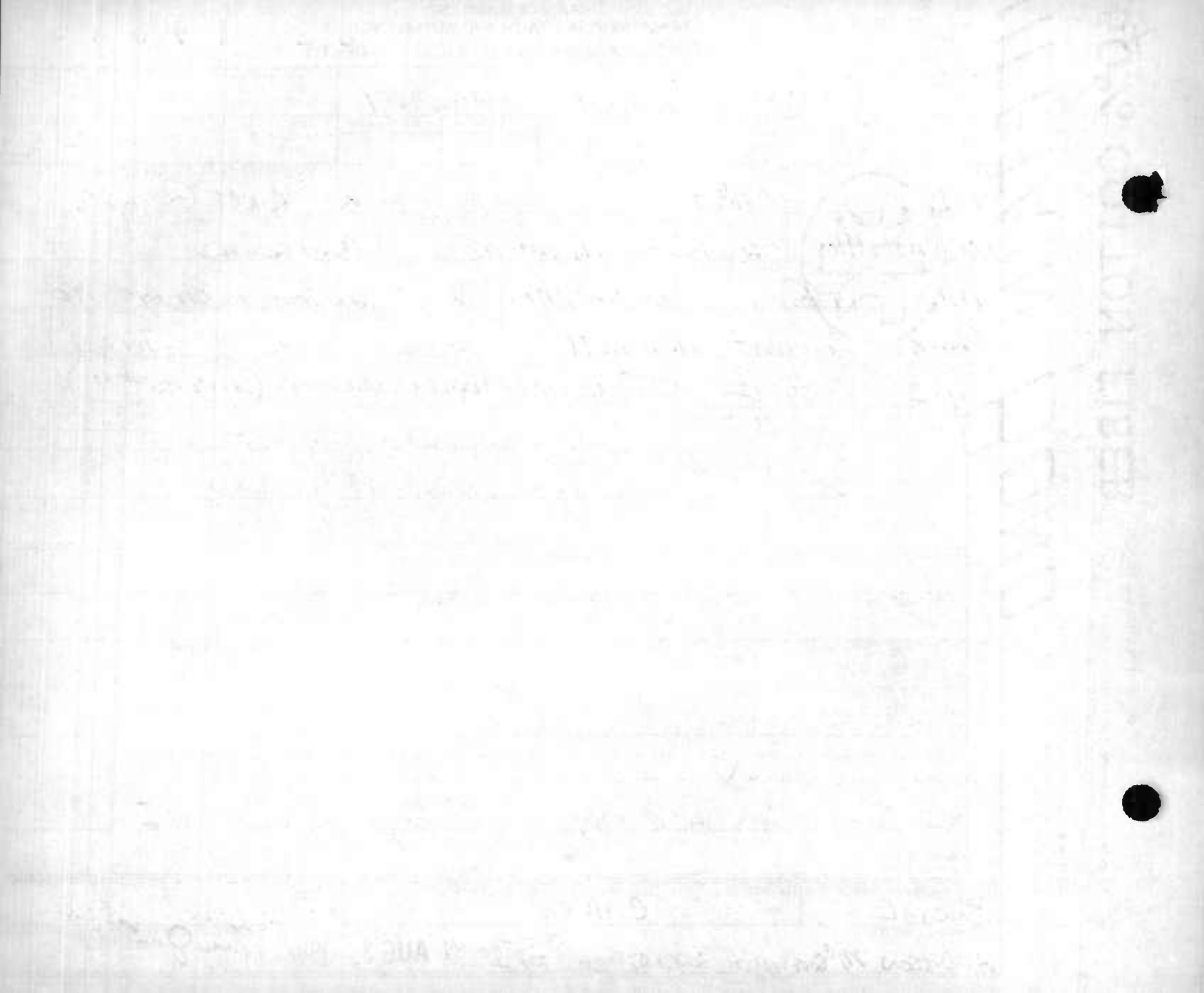
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 401 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19045	
1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES Somerset HAMMETT</b>						2a. DATE KNOWN OF DEATH ESTIMATED <b>7 28 82</b>		2b. HOUR <b>5A</b>			
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH <b>3</b> DAY <b>30</b> YEAR <b>17</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>65</b> YRS.	IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	2c. DATE PRONOUNCED DEAD MONTH <b>7</b> DAY <b>28</b> YEAR <b>82</b>		2d. HOUR <b>530</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b>					
10. CITY OR TOWN OF DEATH <b>New Carrollton</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7600 Fountain Blv Apt 712</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chast Guard</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>		13b. COUNTY <b>PG.</b>		13c. CITY OR TOWN <b>New Carrollton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7600 Fountain Blv Apt 712</b>			
14. FATHER'S NAME FIRST <b>Charles</b> MIDDLE <b>Somerset</b> LAST <b>Hammett</b>				15. MOTHER'S MAIDEN NAME FIRST <b>ROSE</b> MIDDLE <b>N</b> LAST <b>JONES</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW.II</b>		17. INFORMANT ADDRESS <b>Hoppe Goldsboro expt (same as #11)</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Carcinoma of the lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>SAM A-DARE MD</b>		TITLE (SPECIFY) <b>Deputy</b>		M.D. <b>Deputy</b> MEDICAL EXAMINER				DATE SIGNED <b>7-28-82</b>			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>		23d. LOCATION CITY OR TOWN <b>St. Petersburg</b> COUNTY <b>FLA</b> STATE <b>FLA</b>					
24. FUNERAL DIRECTOR NAME <b>ANDERSON McQUEEN F.H.</b>		ADDRESS <b>2201 9th St</b>		CITY OR TOWN <b>St Petersburg</b>		STATE <b>FLA</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 3 1982</b>			

BP





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19046	
1. DECEASED NAME (TYPE OR PRINT) <b>Francis D. Harding, Jr.</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>7 11 1982</b>		2b. HOUR <b>7:50 A.M.</b>			
3. SEX <b>Male</b>	4. RACE <b>Cau.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 21 1956</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>25 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>7 11 1982</b>		2d. HOUR <b>7:50 A.M.</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Texas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George's General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>			
13a. STATE <b>Virginia</b>		13b. COUNTY <b>Fairfax</b>		13c. CITY OR TOWN <b>Alexandria</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>8631 Buckboard Drive 22308</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Francis D. Harding, Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Thomas</b>		17. INFORMANT ADDRESS <b>Parents-Mr. &amp; Mrs. Harding, Sr. 8631 Buckboard Drive, Alexandria, Va.</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		16c. SOCIAL SECURITY NO. <b>225-92-9835</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>8147</b> IMMEDIATE CAUSE (d) <b>Multiple Injuries</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (e) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12:52 PM 7 11 1982</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>pedestrian struck by auto</b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>highway</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1-95 at Woodrow Wilson Bridge, Prince George's Co., Md.</b>							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>		TITLE (SPECIFY) <b>M.D. Assistant</b> MEDICAL EXAMINER						DATE SIGNED <b>7-12-82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>		ADDRESS <b>111 Penn Street</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>July 13 82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington D.C.</b>					
24. FUNERAL DIRECTOR NAME <i>Wayne F. Flood</i> ADDRESS <b>Demaine Funeral Homes, Inc., Alexandria, Va.</b>						25a. DATE REC'D BY REGISTRAR <b>JUL 19 1982</b> SIGNATURE <i>James J. [illegible]</i>					

UNITED STATES

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 9 0 4 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CELINE Ann Harman				2a. DATE OF DEATH MONTH DAY YEAR 07-25-82		2b. HOUR 11:46 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 15, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Food industry	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY PG		13c. CITY OR TOWN Hillside		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur E. Giffin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Long					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 374 26 0437		17. INFORMANT ADDRESS James Harman 7608 Martha Street Forestville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>hepatic failure</i> 3030 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>arteriosclerosis</i> (c) <i>hypertension</i> DUE TO, OR AS A CONSEQUENCE OF: DUE TO, OR AS A CONSEQUENCE OF: PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b): <i>diabetic mellitus, hyperplastic</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)			
22a. I certify that (I) (this hospital) attended the deceased from <i>5/6</i> 19 <i>7/25</i> 19 <i>82</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, do not view the body after death.)							
22b. SIGNATURE <i>L. H. Dennis</i>		22c. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis H. Dennis		22d. ADDRESS 831 University Blvd Silver Spg, Md.		22e. DATE SIGNED 7/26/82	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 27 July 82		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md	
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm		24b. ADDRESS Fnlrl Home Suitland, MD		25a. DATE RECEIVED BY REGISTRAR JUL 30 1982		25b. REGISTRAR'S SIGNATURE <i>James J. Martin</i>	



NOTED

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07-11-19

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UNITED STATES GOVERNMENT

UNITED STATES GOVERNMENT

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH				2b. HOUR			
ERNEST HARRIS										X MONTH DAY YEAR 6 29 1982				M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD					
Male		Negro		SEPT 17 1930		51 YRS.		MONTHS DAYS		HOURS MIN.		6 29 19 82					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
BIRMINGHAM, ALA.				U. S.								P. D. Co.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Capitol Heights				home - 7564 Millwright Street				RETIRED U.S. NAVY									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
MD.				PRINCE GEORGE		Capitol Hgts.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7564 MILLWRIGHT ST, CAPT. HGTS.							
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME									
GEORGE MC RAE								CATHERINE HARRIS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS									
YES				031-30-0203				VIVIAN HARRIS (WIFE) 7564 MILLWRIGHT ST, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease																	
4292																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:																	
(b) _____																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?													
20. AUTOPSY?																	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
				HOUR A.M. MONTH DAY YEAR													
				P.M. 19													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION									
								STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED									
Augusto P. Rodriguez				Deputy				6/29/1982									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Augusto P. Rodriguez M.D.				5009 Rayburn Ct., Temple Hills, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
BURIAL				7-6-1982		ARLINGTON NAT. CEMETERY				ARLINGTON VA.							
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
MONTGOMERY BROS. F.H.				JUL 7 1982				Francis Van Natten									

SECRET



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	1	9	0	4	9
1- FOR STATE REGISTRAR										CERTIFICATE OF DEATH						
1. DECEASED NAME										2a. DATE OF DEATH				2b. HOUR		
FIRST MIDDLE LAST										MONTH DAY YEAR				HOUR		
LEONARD DORREEN HARRIS										JULY 27 1982				1:28a M		
3 SEX		4 RACE		5. DATE OF BIRTH				6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male		White		March 10, 1925				57		MONTHS DAYS		HOURS MIN.				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH										
Missouri		U.S.A.				Prince George's MD										
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Lanham		Doctors' Hospital of Pr. Geo. Co.				Geologist		US Geo. Survey								
13a. STATE										13b. CITY OR TOWN		13c. STREET ADDRESS				
Maryland										P.G. Co. Laurel		6007 Windham Rd.				
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST					FIRST MIDDLE LAST											
William O. Harris					Bertha Wise											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17 INFORMANT					ADDRESS				
Yes WWII					494-20-2007		Anita G. Harris					same as #13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory/cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>gastrointestinal bleeding</u> (c) <u>ruptured aneurysm &amp; hepato renal syndrome</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Px. lung carcinoma, hepatic failure</u>																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
7/26		renal failure - shunt f. dialysis				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
		P.M. 19														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from 7/16, 1982, to 7/27, 1982, that (I) (we) last saw the deceased alive on 7/26, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED						
22b. SIGNATURE Leroy E. Cohen										22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS						
Leroy E. Cohen										6201 Greenbelt Rd. College Park, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE										
Burial		7/30/82		Md. Nat'l Mem Park		Laurel, P.G. Co. Md.										
24. FUNERAL DIRECTOR FLECK LAUREL FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20707										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
										JUL 30 1982		James J. Nathan				

OFFICE OF THE CHIEF, BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY

FROM THE CHIEF, BUREAU OF PLANT INDUSTRY

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

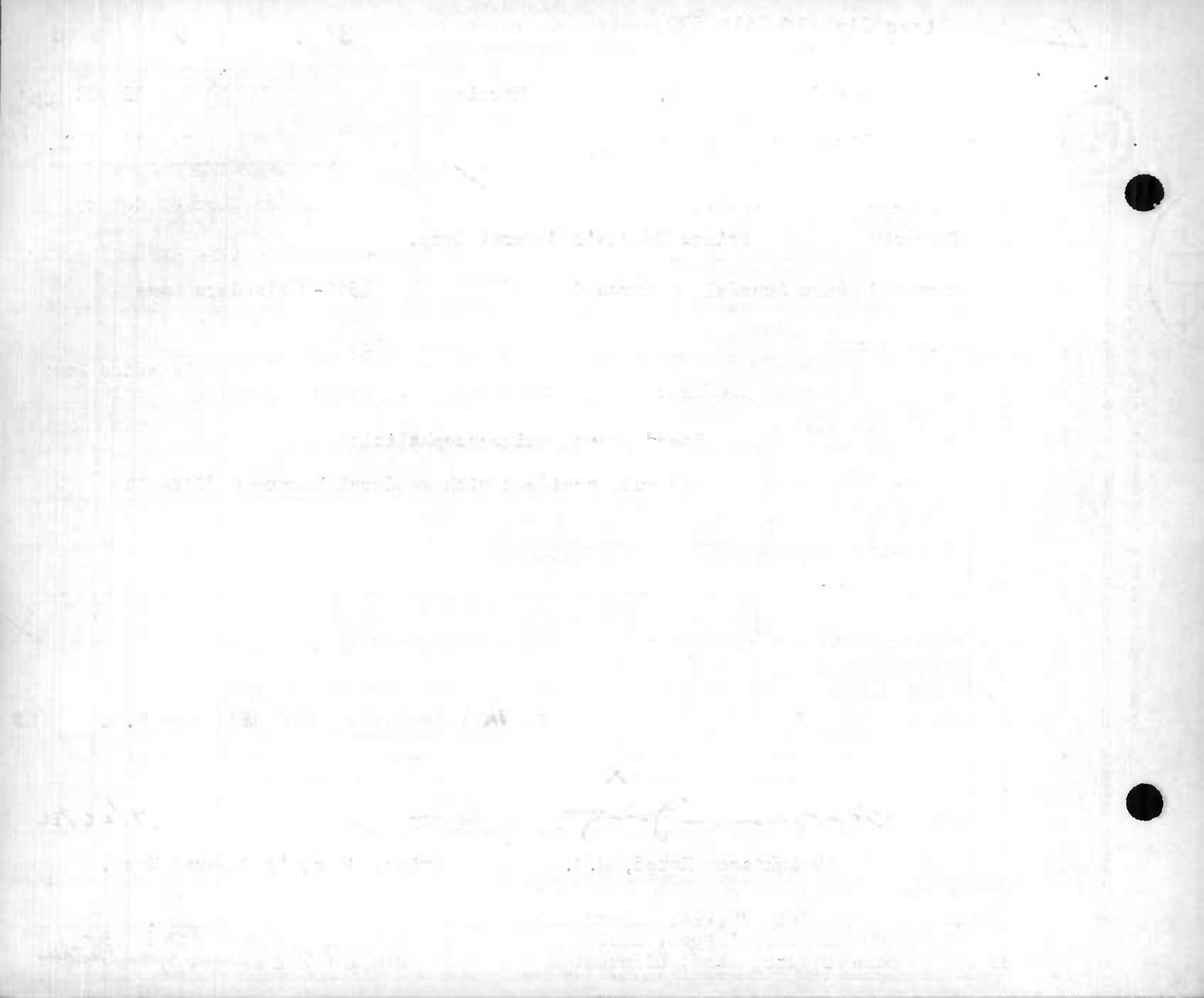
BP

DHMH-17  
(VR A15 ME (5) 6633  
15M 2/80

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) <b>Ronald James Harris</b>							2a. DATE KNOWN OF DEATH MONTH <b>7</b> DAY <b>25</b> YEAR <b>1982</b>		2b. HOUR <b>4:15P</b> M			
3. SEX <b>male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>2</b> YEAR <b>1934</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>47</b> YRS.		IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges County, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George's General Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Computer Instructor</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Engineering</b>		
13a. STATE <b>Maryland</b>							13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Harwood</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Newton</b> MIDDLE <b>Harris</b> LAST <b>Harris</b>							15. MOTHER'S MAIDEN NAME FIRST <b>Grace</b> MIDDLE <b>Hulen</b> LAST <b>Hulen</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>Korean Conflict 536-36-7246</b>			17. INFORMANT <b>Carol S. Harris - Harwood, Maryland</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pseudomonas meningoencephalitis</b> 8199 Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost. (b) <b>Old auto accident with subdural hematoma (5/24/82)</b> (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN <b>Central Ave &amp; Queen Ann Bridge Rd</b> COUNTY <b>P.G.</b> STATE <b>MD</b>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <i>Abolghassem Hatef</i>				TITLE (SPECIFY) <b>Deputy</b> M.D.				MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT) <b>Abolghassem Hatef, M.D.</b>				ADDRESS <b>Prince George's General Hosp.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>July 28, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Clinton</b> COUNTY <b>Pr. Geo.</b> STATE <b>MD</b>			
24. FUNERAL DIRECTOR NAME <b>Lee Funeral Home, Inc.</b> ADDRESS <b>33 Old Alexander Ferry Road, Clinton, MD</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 27 1982</b>			25b. REGISTRAR'S SIGNATURE <i>James Van Nuthen</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove co-ban papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	1	9	0	5	1
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>Lillian C. HARTMAN</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>July 5, 1982</b>				2b. HOUR <b>8:01p.</b>		
3 SEX <b>Female</b>			4 RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>February 21, 1897</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince-Georges</b> MD.							
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Home, Inc.</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Civil Defense</b>				
13a. STATE <b>Maryland</b>			13b. COUNTY <b>A.A.</b>			13c. CITY OR TOWN <b>Crofton</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1715 Dana Street</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas R. Lloyd</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Ellen Cronin</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-40-7417</b>			17. INFORMANT ADDRESS <b>Mary E. Hoover, 1715 Dana St., Md.</b>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>15 years</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cerebrovascular disease, Diabetic Neuropathy</b>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (this hospital) attended the deceased from <b>Jan 2, 1980</b> , to <b>7/5/82</b> , that (we) lost <b>FE</b> above (we) did (did not) view the body after death.																
22b. SIGNATURE <b>Ibrahim M. Khatri</b>						DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>7/5/82</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>IBRAHIM M. KHATRI</b>						22e. ADDRESS <b>6525 Belcrest Rd Hyattsville Md</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7/10/82</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Maria Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Towson, Maryland</b>							
24. FUNERAL DIRECTOR NAME ADDRESS <b>Beall Funeral Home, Inc. 16000 Annapolis Rd., Bowie, Md.</b>						25a. REG'D. BY DEPT. OF HEALTH <b>JUL 12 1982</b>										

BP



10000 Appraisals 84, Bowie, Md.  
Be II Funeral Home  
9/10/82 Mt. Vernon, Md.  
Burlingame

Maryland A.A. Crofton  
1715 Pine Street  
Crofton, Md.  
Mary E. Hoover, 1715 Pine St., W.  
Crofton, Md.

Howard County, Md.

Howard County, Md.

Howard County, Md.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Opal		MIDDLE I		LAST Harvey		2b. DATE KNOWN OF DEATH		ESTI- MATED		MONTH 7		DAY 20		YEAR 1982		2b. HOUR 10:18	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Dec. 13, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH 7		DAY 20		YEAR 1982	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD							
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Geo. Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk				12b. KIND OF BUSINESS OR INDUSTRY U.S. Treasury Dept.							
13a. STATE Maryland				13b. COUNTY P.G.		13c. CITY OR TOWN Glenn Dale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6728 Glenn Dale Road									
14. FATHER'S NAME FIRST MIDDLE LAST John McCammon				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lydia Rothenberger				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No											
16b. SOCIAL SECURITY NO. 577-10-6986				17. INFORMANT ADDRESS Mr. George B. Harvey Address Same as No# 13e.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia &amp; urinary tract infection &amp; pneumonia</u> 3310 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>Fractured femur, 4 months ago</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Alzheimer's disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <i>Alhaghassem Hatef</i>				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER				DATE SIGNED 7/21/82							
EXAMINER'S NAME (TYPE OR PRINT) Alhaghassem Hatef, M.D.				ADDRESS Cheverly, MD. 20785															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7-24-82				23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland							
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A.				ADDRESS Hyattsville, Md.				25a. DATE REC'D. BY REGISTRAR JUL 23 1982				25b. REGISTRAR'S SIGNATURE <i>Francis J. [Signature]</i>							



F. Charles Sons M.H. T.A. Hyattsville, Md.

Postal 7-24-62 Ft. Lincoln Cemetery Bowie, Md. T.A. Maryland

*Handwritten signature*

*Handwritten notes:*  
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10/30/62  
10/31/62

No

577-10-6982

Mr. George H. Harvey

Not 150.

John

McGowan

Lydia

Address Book as

Maryland

T.A.

Clara Dale

x

6720 Clara Dale Road

Chief

Treasury Dept.

Kansas

U.S.A.

x

Prince George's County

74

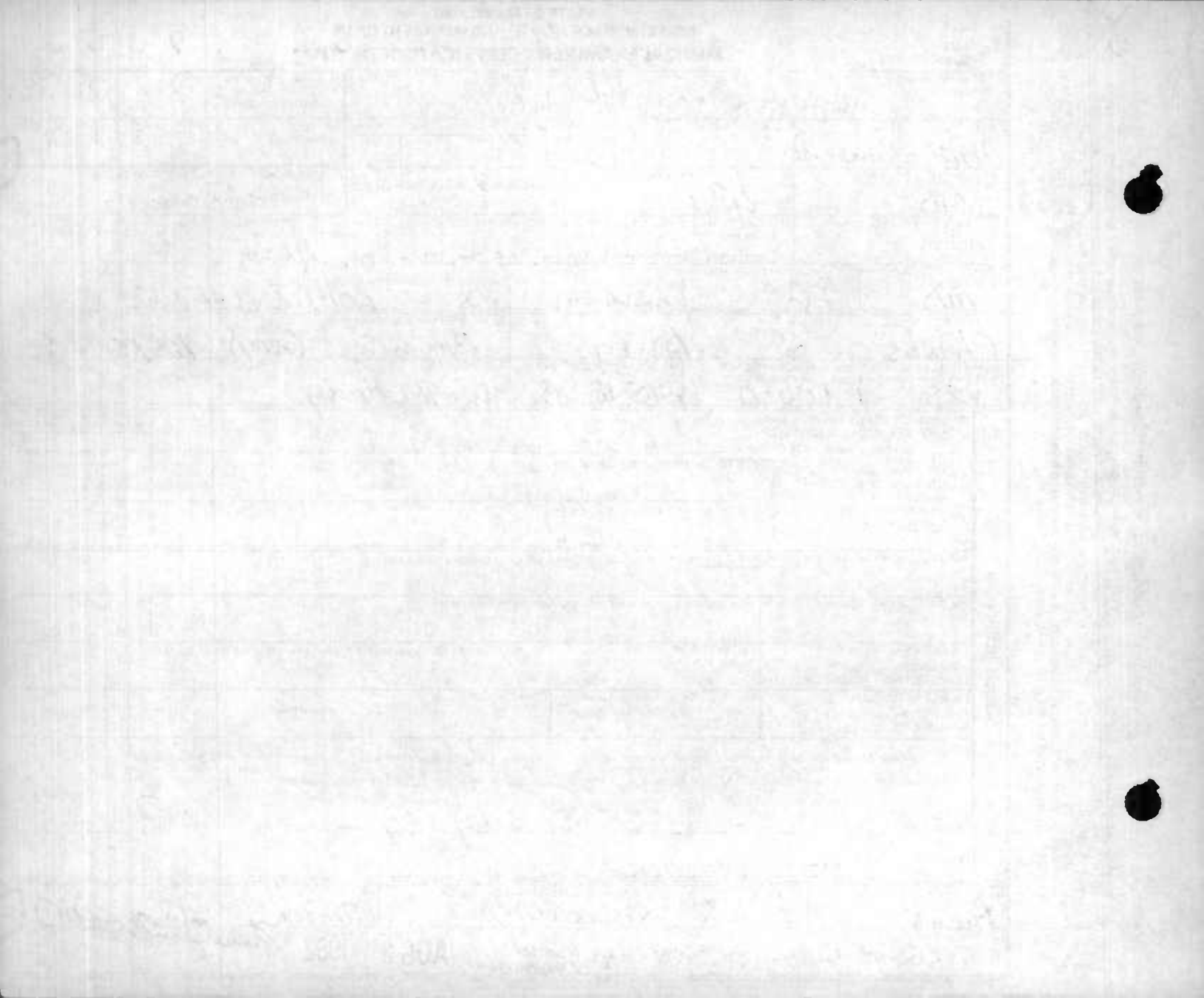
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR	
WARREN GLEN HARVEY								7 27 82				19				11.23 M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
MALE	CAUCASIAN	2 5 80		62 YRS.						7 27 82		19				11.23 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
MD		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Lanham		Lanham Doctors' Hosp. of Pr. Geo. Co.		NASA													
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MD		PG.		LANHAM		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6014 NOLAN AVE									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST							
CLARKS		S		HARVEY		MAGGIE		ANNIE		MCKENZIE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
YES		LWW II		6215-18-8482		LAWYER HARVEY											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
2500		Cardiac arrest															
		(b)		in of m/		DUE TO, OR AS A CONSEQUENCE OF											
		(c)		Diabetes													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
SAID A. DAEE M.D.		Deputy		7-28-82													
EXAMINER'S NAME (TYPE OR PRINT)		SAID DAEE, M.D.		ADDRESS													
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)		STATE									
Burial		30 July 82		Resurrection		Chintons		MD									
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		REGISTRATION NO.											
Louis L. Grant		Lanham, MD		AUG 3 1982													

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR OUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



Items #10a-22a Film G570 8/23/82 re  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 19054

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
JAMES L. HATCHER, JR.								7 25 19 82								M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M	Black	May 5 1943		39 YRS.						7 27 19 82						8:30 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
D.C.		U.S.A.		WIDOWED		DIVORCED		Prince George's County								MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Suitland		4200 Eastern Lane		Lawyer													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md		P.G.		Suitland		YES		4800 Eastern Lane									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
James Lee Hatcher Sr		Lucy D. Hancock															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		1968 to 1972		578-56-3998		Lucy Hatcher		900 E St N.E		D.C.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Alcoholism																	
3030																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
DUE TO, OR AS A CONSEQUENCE OF																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES		NO											
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2											
		HOUR A.M. MONTH DAY YEAR															
		P.M. 19															
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on		Autopsy		Inspection		Inquiry		and in my opinion									
death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Ann M. Dixon, M.D.		M.D. Assistant		7-28-82													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Ann M. Dixon, M.D.		111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
		7-31-82		Lincoln Memorial		Suitland Rd		P.G.		Calver							
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
H. Washington		4925		Burrroughs Ave N.E D.C.		AUG 11 1982											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 2 1 9 0 5 5

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Rose</b> <b>S</b> <b>Heberle</b>			2a DATE OF DEATH MONTH DAY YEAR <b>7-1-82</b> <b>July</b> <b>1</b> <b>1982</b>			2b HOUR <b>3:55</b> <b>pm</b>				
3 SEX <b>Female</b>		4 RACE <b>white</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>July</b> <b>4</b> <b>1892</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Green New York</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges County</b> MD.				
10 CITY OR TOWN OF DEATH <b>Hyattsville Md</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Manor</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Registered nurse</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Health care</b>				
13a STATE <b>MD</b>			13b COUNTY <b>Washington DC</b>		13c CITY OR TOWN <b>Washington DC</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>Bellvue Hotel</b> <b>15 E Street NW</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Joseph A Heberle</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna S Welch</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>unknown</b>			16b SOCIAL SECURITY NO. <b>578-624746</b>		17 INFORMANT ADDRESS <b>Jeanne Rurals 1831 NE 38th #102</b>				17b <b>H Raudordale</b> <b>71A. 33308</b>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: <b>4340</b> IMMEDIATE CAUSE (a) <b>Progressive Cerebro Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebrovascular Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1 year</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (the physician) attended the deceased from <b>June 29</b> , 19 <b>82</b> , to <b>July</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>June 29</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <b>see</b> the body after death.										
27b SIGNATURE <b>James J. Foster M.D.</b>			DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <b>7/1/82</b>				
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES FOSTER</b>			22e ADDRESS <b>WASHINGTON, D. C.</b>							
23a BURIAL CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b DATE <b>7/6/82</b>		23c NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SUITLAND PRI GEO MD.</b>			
24 FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>					25a DATE REC'D. BY REGISTRAR <b>JUL 8 1982</b> 25b REGISTRAR'S SIGNATURE <b>James J. Foster</b>					
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901										

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*



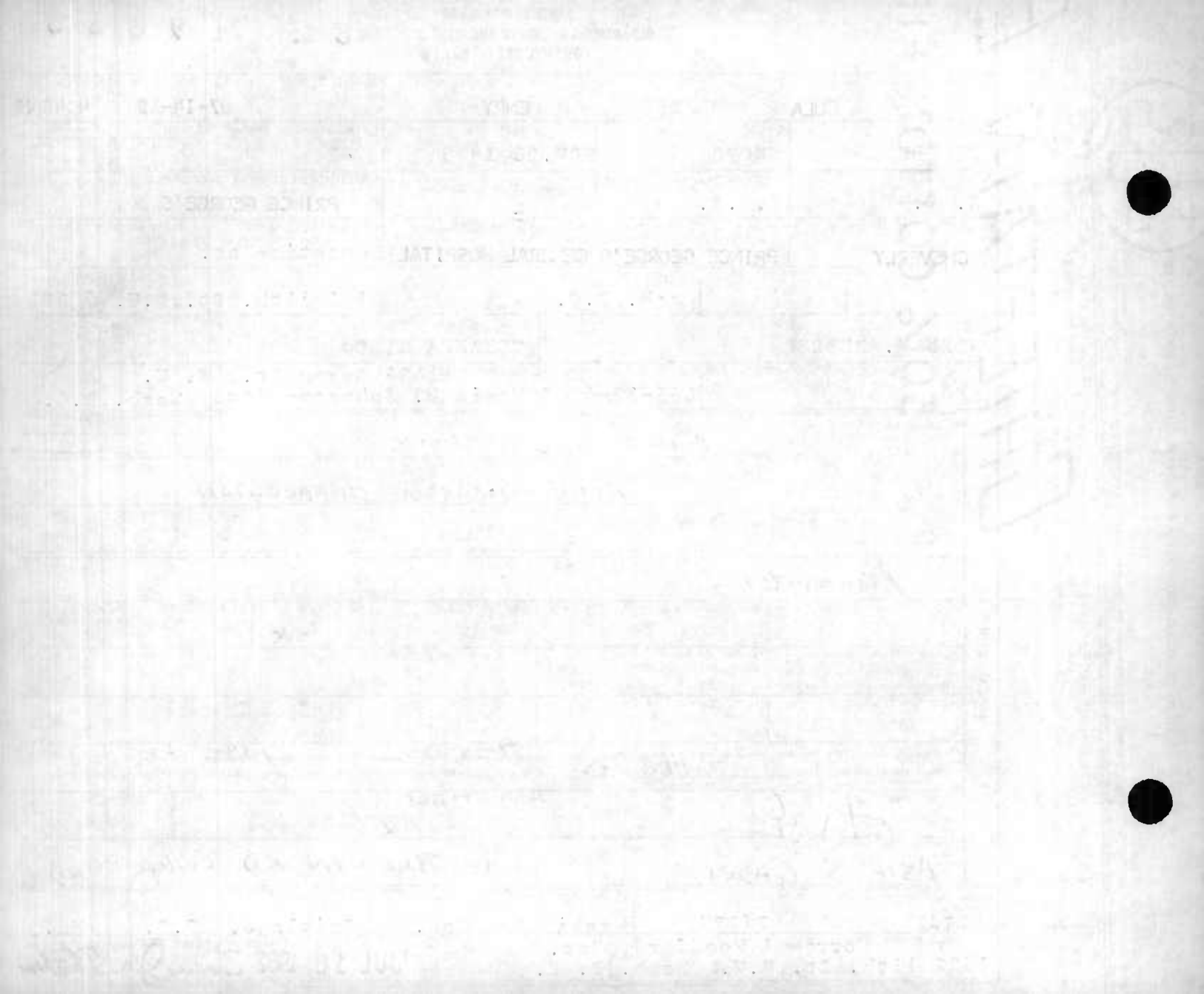
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 2 1 9 0 5 6	
1 - STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				REG. NO.	
EULA REEDER HENRY				2a. DATE OF DEATH MONTH DAY YEAR 07-14-82 2b. HOUR 4:40AM	
3. SEX FEMALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR NOV. 23, 1899	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. C.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		6. AGE (IN YEARS LAST BIRTHDAY) 82	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
13a. STATE		13b. COUNTY		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN H. REEDER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TEXANNA MINGO		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic-Ret.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES AND OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 465-38-4095		17. INFORMANT ADDRESS 1434 Swann St., N. W. Mamie H. Johnson-Niece Wash., D.C.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 CARDIOGENIC SHOCK					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pancreatitis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
22a. I certify that (I) (this hospital) attended the deceased from 7-12-1982, to 7-14-1982, that (I) (we) last saw the deceased alive on 7-14-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE ASIF S. QADRI		DEGREE MBBS ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ASIF S. QADRI		22e. ADDRESS 4713 - BERWYN RD, College Pk MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/17/82		23c. NAME OF CEMETERY OR CREMATORY Washington Nat.	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G. Md.		25a. DATE REC'D BY REGISTRAR 7 JUL 16 1982			
24. FUNERAL DIRECTOR'S NAME Morrow & Woodford, Inc. 1622 11th. St., N.W. Wash., D. C.		25b. REGISTRAR'S SIGNATURE Frances Jan Nathan			

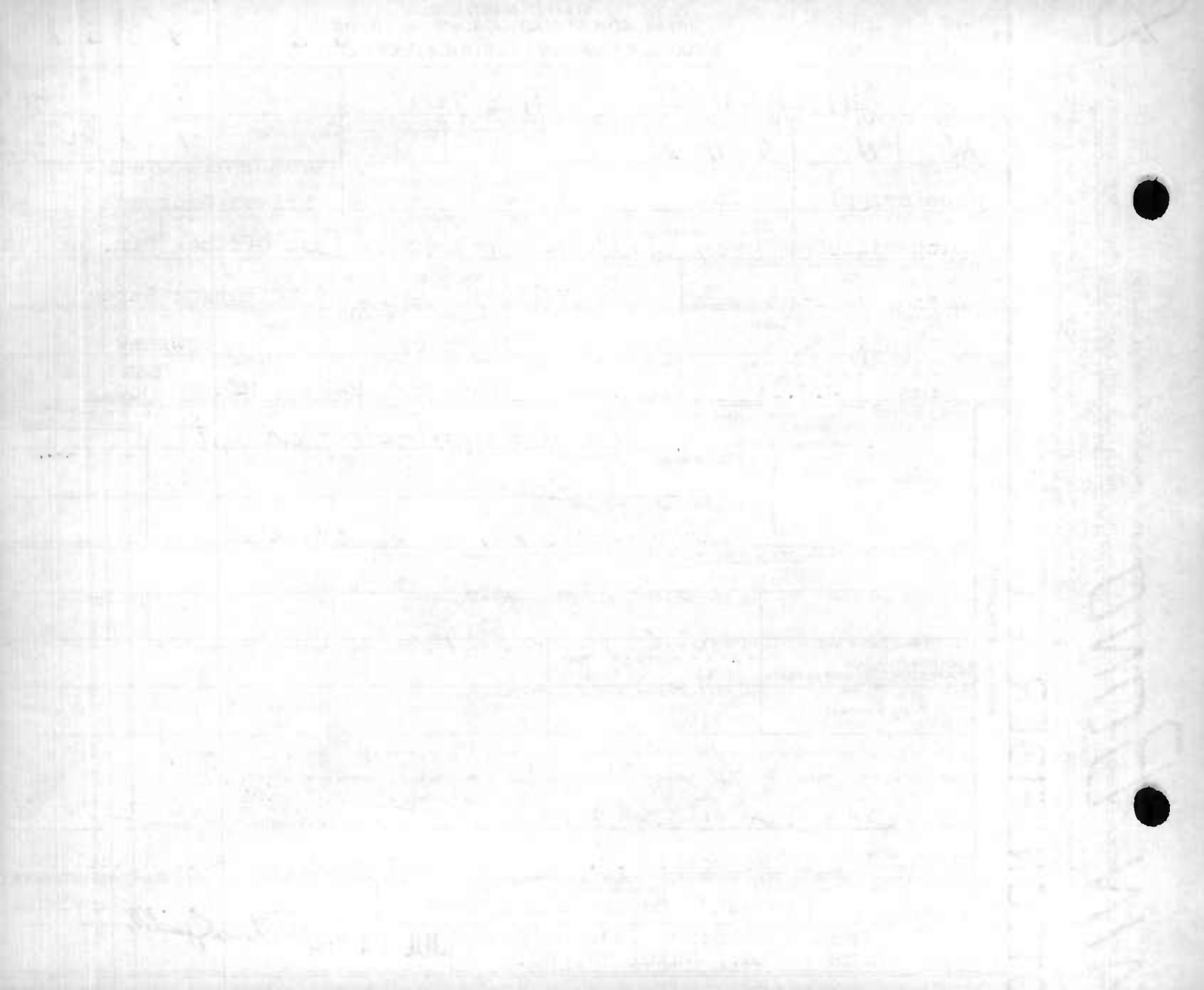
BP \_\_\_\_\_



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8219057	
1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
DECEASED NAME (TYPE OR PRINT) <b>HIRAM J. Hodges</b>										MONTH DAY YEAR <b>7 7 1982</b>	
SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH (MONTH DAY YEAR) <b>9 11 1922</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>69 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD <b>7 7 1982</b>		2d. HOUR <b>2:20 PM</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mississippi</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's MD</b>					
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1509 Jefferson St Hyattsville</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Post Office</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dir. of Fin</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>	13b. COUNTY <b>PG</b>	13c. CITY OR TOWN <b>Hyattsville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>1509 Jefferson Street</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Zebulin Hodges</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Swiney</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>W.W.II</b>		17. INFORMANT <b>Margaret Hodges, Wife</b>		ADDRESS <b>Same as Above</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100 Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>ASVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Previous MI and stroke</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>SAND A. DAE M.D.</b>						TITLE (SPECIFY) <b>Deputy</b>		DATE SIGNED <b>7-7-82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Said A. Dae, M.D.</b>				ADDRESS <b>5632 Annapolis Rd., Hyatt. Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>7-9-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, P.G. Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Robt E Wilhelm</b>				ADDRESS <b>4308 Suitland Rd., Suitland, Md.</b>				25. DATE REC'D BY REGISTRAR <b>JUL 14 1982</b>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME OR TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19058	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>George L. HOFF, SR</b>						2a. DATE KNOWN OF DEATH <b>7-3-82</b>		2b. HOUR <b>5:00</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>9-20-12-69</b>		6. AGE (IN YEARS) <b>69</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington DC</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b>		
10. CITY OR TOWN OF DEATH <b>Frutville</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>1996 Rochelle Avenue Apt 2</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Meat Cutter</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Briggs Co.</b>		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Pr George</b>			13c. CITY OR TOWN <b>Dist Hgts</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <b>1996 Rochelle Avenue</b>											
14. FATHER'S NAME <b>John G Hoff</b>						15. MOTHER'S MAIDEN NAME <b>Margaret T Fink</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>						16b. SOCIAL SECURITY NO. <b>578-09-0495</b>			17. INFORMANT <b>Sea Brook, Md. George L Hoff, Jr 9353 Worrell Ave</b>		
18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4292 Arteriosclerotic cardiovascular disease</b> IMMEDIATE CAUSE (a) <b>DUE TO, OR AS A CONSEQUENCE OF</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>DUE TO, OR AS A CONSEQUENCE OF</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Diabetes mellitus</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>						TITLE (SPECIFY) <b>M.D. Deputy</b>			DATE SIGNED <b>7-3-82</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez M.D.</b>						ADDRESS <b>5009 Rayburn Ct., Temple Hills, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6 July 82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Robert E Wilhelm</b>						ADDRESS <b>Suitland Maryland</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 7 - 1982</b>		
						25b. REGISTRAR'S SIGNATURE <b>Frances Jean Nathan</b>					



George - 1807-1808  
New York 1807-1808

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1807-1808

Chapman's

Book

Chapman's

1807-1808

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR										
CERTIFICATE OF DEATH										
REG. NO.										
1. DECEASED NAME (TYPE OR PRINT) <b>JULIUS HOPKINS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 8 1982</b>					2b. HOUR <b>7.43P.M.</b>
3 SEX <b>Male</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 4 1921</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>61</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE;S COUNTY MD</b>				
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE;S GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD.</b>					13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Seat Pleasant</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Julius A. Hopkins</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine C. Hopkins</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>579-18-6225</b>		17. INFORMANT ADDRESS <b>Wash. D.C.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Obstructive Pulmonary Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Chronic Atrial Fibrillation</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>July 1</b> , 19 <b>82</b> , to <b>July 7</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>July 7</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did <del>not</del> view the body after death.										
22b. SIGNATURE <b>John O. Stanley MD</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>7/9/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN O. STANLEY MD</b>					22e. ADDRESS <b>PGMH &amp; MC Cheverly, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7-13-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Md</b>		
24. FUNERAL DIRECTOR NAME <b>Johnson &amp; Jenkins</b>					ADDRESS <b>716 KENNEDY ST. N.W.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 28 1982</b>			



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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

19060

1. DECEASED NAME (TYPE OR PRINT)		FIRST PATRELLIA		MIDDLE KAREN		LAST HORN		2a. DATE KNOWN OF ESTI- MATED		MONTH July		DAY 7		YEAR 82		2b. HOUR 4PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH Aug		DAY 2		YEAR 50		6. AGE (IN YEARS) LAST BIRTHDAY 32 YRS.		IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. DAYS		7c. DATE PRONOUNCED DEAD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD											
10. CITY OR TOWN OF DEATH LAUREL		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 939 PARKHILL ROAD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAREHOUSE CLERK		12b. KIND OF BUSINESS OR INDUSTRY J.A. NEARING											
13a. STATE MARYLAND		13b. COUNTY PRINCE GEORGES		13c. CITY OR TOWN LAUREL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 939 PARKHILL ROAD 20707									
14. FATHER'S NAME FIRST JOHN		MIDDLE W.		LAST HYRE		15. MOTHER'S MAIDEN NAME FIRST ELIZABETH		MIDDLE TACY		LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		IF YES, GIVE WAR OR DATES		16b. SOCIAL SECURITY NO. 213-56-7969		17. INFORMANT MOTHER		ADDRESS 42609 PARKLAND DRI ROCKVILLE, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> 1790 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>Carcinoma of uterus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>with metastasis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE SAID A. DAE		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER										DATE SIGNED 7-7-82			
EXAMINER'S NAME (TYPE OR PRINT) SAID A. DAE, M.D.		ADDRESS 5632 ANNAPOLIS RD., BLADENSBURG, MD.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/10/82		23c. NAME OF CEMETERY OR CREMATORY BRICK CHURCH CEMETERY		23d. LOCATION CITY OR TOWN HUTTONSVILLE COUNTY WEST VA.											
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25a. DATE REC'D. BY REGISTRAR JUL 12 1982		25b. REGISTRAR'S SIGNATURE Francis J. Collins													
25c. DATE REC'D. BY REGISTRAR JUL 12 1982		25d. REGISTRAR'S SIGNATURE Francis J. Collins															



REDIRECT



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be examined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 9 0 6 1	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>William M. Hunt</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>July 5, 1982</b>			2b. HOUR <b>12:20p.m.</b>		
3 SEX <b>Male</b>		4 RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 1 1920</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>62</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD.					
10 CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fed. Gov't.</b>			
13a. STATE <b>Md.</b>						13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Camp Springs</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Joseph B. Hunt</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella B. Leach</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17 INFORMANT ADDRESS <b>Anna E. Hunt same as item 13</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of Lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Chronic Obstructive Lung Disease</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>7/5</u> 19 <u>82</u> , to <u>7/5</u> 19 <u>82</u> , that (I) <u>lost</u> saw the deceased alive on <u>7/5</u> 19 <u>82</u> , and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death.											
22b. SIGNATURE <b>Dr. Louis V. Kaufman, MD</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/6/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Louis V. Kaufman, MD</b>						22e. ADDRESS <b>10905 Ft. Wash. Rd. Suite 406</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>7/8/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wash St. Meth. Ch. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alex. Va.</b>			
24 FUNERAL DIRECTOR NAME ADDRESS <b>G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.</b>						25a. DATE RECD. BY REGISTRAR <b>JUL 9 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Martin</b>			

G.P. Weiss 6160 Oxon Hill Rd. Oxon Hill, Md.

Partial

7/8/82

Wash St. Beth. Ch. Com. Alex.

Yes

Mr. Louis V. Kaufman, MD

1090 E. Wash. St. Suite 106

Yes

Will

278-12-3478 Anna R. Hunt same as item 13

Joseph

R.

Hunt

Wife

R.

Beach

Mr.

Dr. Geo.

Camp Springs

x

1710 Jean Marie Dr.

Clinical

Southern Maryland Hospital Center Retired

Ref. Gov't.

Male

Cauc.

May

1920

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Prince George

USA

Wash D.C.

William

M.

Hunt

July 2, 1982

**FOR STATE  
HEALTH DEPT.**

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

19062

1. DECEASED-NAME (Type or Print)			First Middle Last <b>GENE THOMAS HUTCHISON</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>7-3 1982</b>			2b. HOUR <b>7:45</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JAN. 15, 1928</b>		6. AGE (In years last birthday) <b>54</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>PRINCE GEORGES</b>			10. CITY OR TOWN OF DEATH <b>A.A.F.B.</b>		
11. NAME OF HOSPITAL OR INSTITUTION (If not hospital give street address) <b>HOSPITAL MALCOLM GROW BASE</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <b>ALCOHOLIC CONDITIONING</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>PRIVATE COMPANY.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>				13b. COUNTY <b>PR. GEO'S</b>				13c. CITY OR TOWN <b>FORESTVILLE</b>			
14. FATHER'S NAME First Middle Last <b>LEONARD HUTCHISON</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>MINNIE SIMPSON</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes give unit or dates of service) <b>W.W. II</b>			
16a. SOCIAL SECURITY NO. <b>579-36-9871</b>				17. INFORMANT <b>FRANCES I. HUTCHISON</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Antenatal cardiac disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Augusto Rodriguez</b> EXAMINER'S NAME (Type) <b>AUGUSTO RODRIGUEZ, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <b>5009 HAYBURN COURT CAMP SPRINGS MD 20748</b>				22b. DATE SIGNED <b>JULY 3, 1982</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE <b>7/7/82</b>				23c. NAME OF CEMETERY OR CREMATORY <b>SOUTHERN MEMORIAL GARDENS, INC.</b>			
23d. LOCATION (City or Town) (County) (State) <b>DUNKIRK (CALVERT CO) MD.</b>				24. FUNERAL DIRECTOR ADDRESS <b>RICHARD A. COLEMAN-UPPER MARLBORO, MARYLAND 20772</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 6 1982</b>			
25b. REGISTRAR'S SIGNATURE <b>Frances Jan. Northern</b>											

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the coroner's department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Ernest A Jackson</b>			2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>7 25 82</b>		2b. HOUR M <b>10:58</b>
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 2, 1900</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>81</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Railway Express Driver Express</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince George</b>	13c. CITY OR TOWN <b>Clinton</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph A. Jackson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary C. Langley</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-03-4316</b>		17. INFORMANT ADDRESS <b>12903 Marcia Pl. Clinton, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>		TITLE (SPECIFY) M.D. <b>Assistant</b>		DATE SIGNED <b>7/26/82</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>		ADDRESS <b>111 Penn Street, Balto. MD 21201</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/28/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
24. FUNERAL DIRECTOR NAME <b>George P. Kalas</b>		6160 Oxon Hill Rd. <b>Home Oxon Hill, Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P.G. Maryland</b>	
DATE REC'D. BY REGISTRAR <b>JUL 29 1982</b>		REGISTRAR'S SIGNATURE <i>James J. [illegible]</i>			

Case 12-03-1316

U.S.A.

Deliver  
Railway Express Driver Express

Clinton George Prince George

Joseph A. Jackson Mary C. Langley

12-03-1316 Miss Perovsky Clinton, Maryland 12-03-1316

George P. Wilson Funeral Home Oron Hill, Md.  
12-03-1316  
Cedar Hill Cemetery  
Oron Hill, Md.  
12-03-1316  
Oron Hill, Md.

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 9 0 6 4			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				3. HOUR			
Richard A. Jacobs				07 2 82				6:05 P.M.			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7. MONTHS		7. DAYS	
Male		Black		07 10 1911		70 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Washington, D.C.		USA		Prince George's County, MD.							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George's Gen. Hosp./Med. Ctr.				Painter					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland				Prince Geo.		Landover		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3636 Cousins Drive	
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
Richard B. Jacobs, Sr.				Ethel B. Scott							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES				16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
yes				577 07 1289		Pericles Jacobs, Jr. - nephew - 2330 Good Hope Road, S.E.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Barry M. Shmookler, MD				MD						July 3, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Barry M. Shmookler, MD				Cheverly, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				July 7, 1982		Lincoln Memorial Cemetery		Suitland, Md.			
24 FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Stewart Funeral Home				4001 Benning Road N.E.				JUL 8 1982		Name	

Table A. 1900-1901

Table A. 1900-1901  
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Table A. 1900-1901

Table A. 1900-1901

Table A. 1900-1901

Table A. 1900-1901

Table A. 1900-1901

Table A. 1900-1901

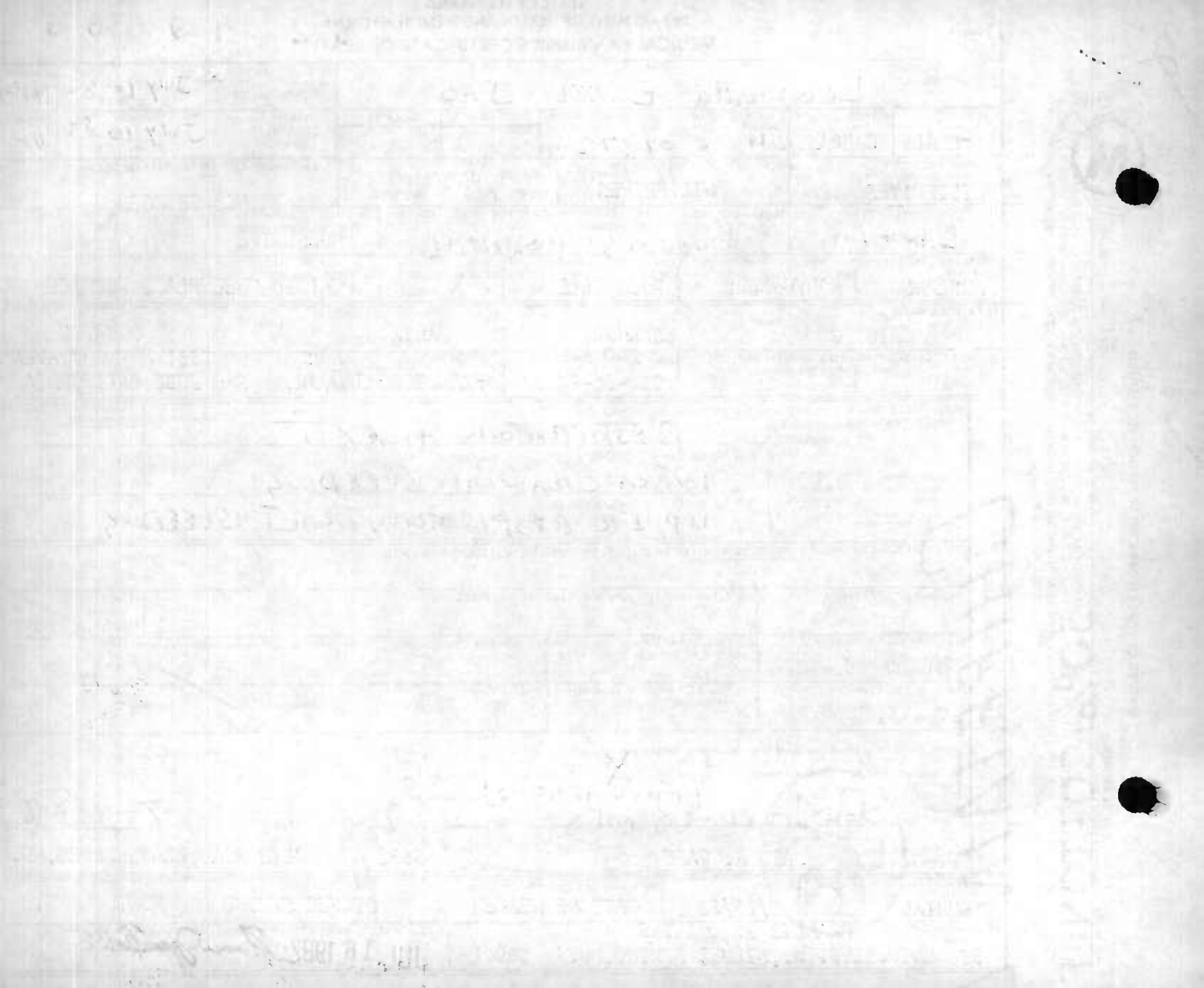
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ENCOUNTERED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 AND ALL FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19065	
1. DECEASED NAME (TYPE OR PRINT) <b>Leonarda ESPANOL JAO</b>										20. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>July</b> DAY <b>10</b> YEAR <b>1982</b> 26 HOUR <b>11 PM</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH <b>11</b> DAY <b>6</b> YEAR <b>1972</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	21. DATE PRONOUNCED DEAD MONTH <b>July</b> DAY <b>10</b> YEAR <b>1982</b> 24 HOUR <b>11 PM</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PHILIPPINES</b>		7b. CITIZEN OF WHAT COUNTRY? <b>PHILIPPINES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b> MD					
10. CITY OR TOWN OF DEATH <b>Lanham</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Doctors' Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>MONTGOMERY</b> 13c. CITY OR TOWN <b>ROCKVILLE</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>BRIGIDO</b> MIDDLE <b>ESPANOL</b> LAST <b>ESPANOL</b>				15. MOTHER'S MAIDEN NAME FIRST <b>MARIA</b> MIDDLE <b>DONAYRE</b> LAST <b>DONAYRE</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-80-9425</b>		17. INFORMANT <b>SON</b> ADDRESS <b>3331 NORWOOD AVENUE</b>		17b. <b>SAN JOSE, CALIFORNIA</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4329 IMMEDIATE CAUSE (a) RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>INTRACRANIAL BLEEDING</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>UPPER RESPIRATORY TRACT BLEEDING</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>SAID A. DAE</b>		M.D. <b>SAID A. DAE</b>		TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>7-11-82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>SAID A. DAE</b>		ADDRESS <b>5632 ANNAPOLIS ROAD, BLADENSBURG, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7/13/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>				23d. LOCATION (SPECIFY) <b>SILVER SPRING</b> COUNTY <b>MONT</b> STATE <b>MD.</b>			
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 16 1982</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19066	
1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>FLOY</b>		MIDDLE <b>McLAUGHLIN</b>		LAST <b>JENKINS</b>		2a. DATE KNOWN OF DEATH		2b. HOUR	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 17, 1925</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>56</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
<b>Washington D.C.</b>		<b>U.S.A.</b>				<b>Prince Georges</b>		<b>Laurel</b>		<b>Greater Laurel Beltsville Hospital</b>	
12. SPECIAL OCCUPATION (TYPE OF WORK)		13. MIND OF BUSINESS (INDUSTRY)		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT	
<b>Development Specialist</b>		<b>Smoking Instiute</b>		<b>High D. McLaughlin</b>		<b>Floy Southworth</b>		<b>578-22-3914</b>		<b>Alicia C. Hampshire North Beach, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Said A. Dae M.D.</b>		TITLE (SPECIFY) <b>Medical Examiner</b>		DATE SIGNED <b>7-10-82</b>		EXAMINER'S NAME (TYPE OR PRINT) <b>Said A. Dae, M.D.</b>		ADDRESS <b>5632 Annapolis Road Bladensburg, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	
23b. DATE <b>7/14/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington National Cem.</b>		23d. LOCATION CITY OR TOWN <b>Suitland</b>		COUNTY <b>P.G.</b>		STATE <b>Maryland</b>		24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland</b>	
25a. DATE REC'D. BY REGISTRAR <b>JUL 14 1982</b>		25b. REGISTRAR SIGNATURE <b>Thane J. Smith</b>									





1944, 17, 1925

Washington D.C.

1944

George Washington

Developmental Psychology Institute

2012 37th Avenue

Princeton University

Princeton

Southwest

Flory

McNish

High

2012 37th Avenue

Office C. Hampshire North Beach, N.H.

37th Avenue

No



John A. Jones, D.D.

John A. Jones, D.D.

Princeton University, Princeton, N.J.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 9 0 6 7			
1. FOR STATE REGISTRAR					REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					MONTH DAY YEAR		2b. HOUR P M	
ROBERT E. JENNINGS					07 02 82					4:45		P M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE		BLACK		OCTOBER 7, 1920		61		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
SOUTH CAROLINA		U.S.A.				PRINCE GEORGE'S COUNTY MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
CHEVERLY		PRINCE GEORGE'S GENERAL HOSPITAL				SOLID WASTE COLL ECTION		D.C. GOVT.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MARYLAND		P.GEO.		CAP. HTS.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		708 NOVA AVENUE					
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME								
LINDEN JENNINGS					MATTIE NEWKIRK								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
NO					-0-		577 01 1519, ELIZABETH JENNINGS 708 NOVA AVE., CAP. HTS., MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <i>lung failure</i>													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>non resectable carcinoma of pancreas</i>										6 weeks			
DUE TO, OR AS A CONSEQUENCE OF (c) <i>well obstructed pancreas</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
<i>metastases from carcinoma</i>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART 1 OR PART 2)							
				HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED				21e. PLACE OF INJURY		21f. LOCATION							
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>				[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>5/2/82</i> to <i>7/2/82</i> that (I) (we) last saw the deceased alive on <i>7/2/82</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
<i>Jerome Sandler</i>								<i>7/3/82</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
JEROME SANDLER, M.D.				6490 LANDOVER RD. LANDOVER, MD. 20785									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION					
BURIAL			7/8/82		FORT LINCOLN			CITY OR TOWN COUNTY STATE					
								BRENTWOOD MARYLAND					
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR							
ROLLINS FUNERAL HOME, INC.						JUL 13 1982							
4339 HUNT PLACE, N.E.													



CHESLEY PRINCE GEORGE'S ISLAND HOSPITAL

JUL 13 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		7b. HOUR		P	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		7b. HOUR	
Ethel Johnson				July 11 1982		5:20		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Female		White		MONTH DAY YEAR		88 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
England		Britian				Prince George's			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Forestville		Regency Nursing Home		Housewife					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		PG		Hillcrest Hgts		NO <input type="checkbox"/>		4106 Murdock Street	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST					FIRST MIDDLE LAST				
Thomas Smart					Caroline Essom				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
No					578-62-8146				
17. INFORMANT					ADDRESS				
Joyce Caplinger, Daughter					Same as Above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:									
4360 IMMEDIATE CAUSE (a) Cardiac Arrest									
DUE TO, OR AS A CONSEQUENCE OF (b) Hypostatic Pneumonia									
DUE TO, OR AS A CONSEQUENCE OF (c) Status Post Left Hemiplegic Stroke									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Generalized Arteriosclerotic Cardiovascular Dis.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from June 19 65, to June 19 82, that (I) (we) lost saw the deceased alive on June 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Richard A. Farson, M.D.						7-12-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR					
Richard A. Farson, M.D.		9401 Indianhead Highway		JUL 15 1982					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		7-15-82		Caplinger Cemetery		Rockingham, Va.			
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR			
Robt E Wilhelm		4308 Suitland Rd., Suitland, Md.		JUL 15 1982		Name			



Cardiac Arrest  
Hypertensive Pulmonary  
Edema, Right Left Heart Failure  
Pneumonia, Myocardial Infarction, Coronary Artery Disease

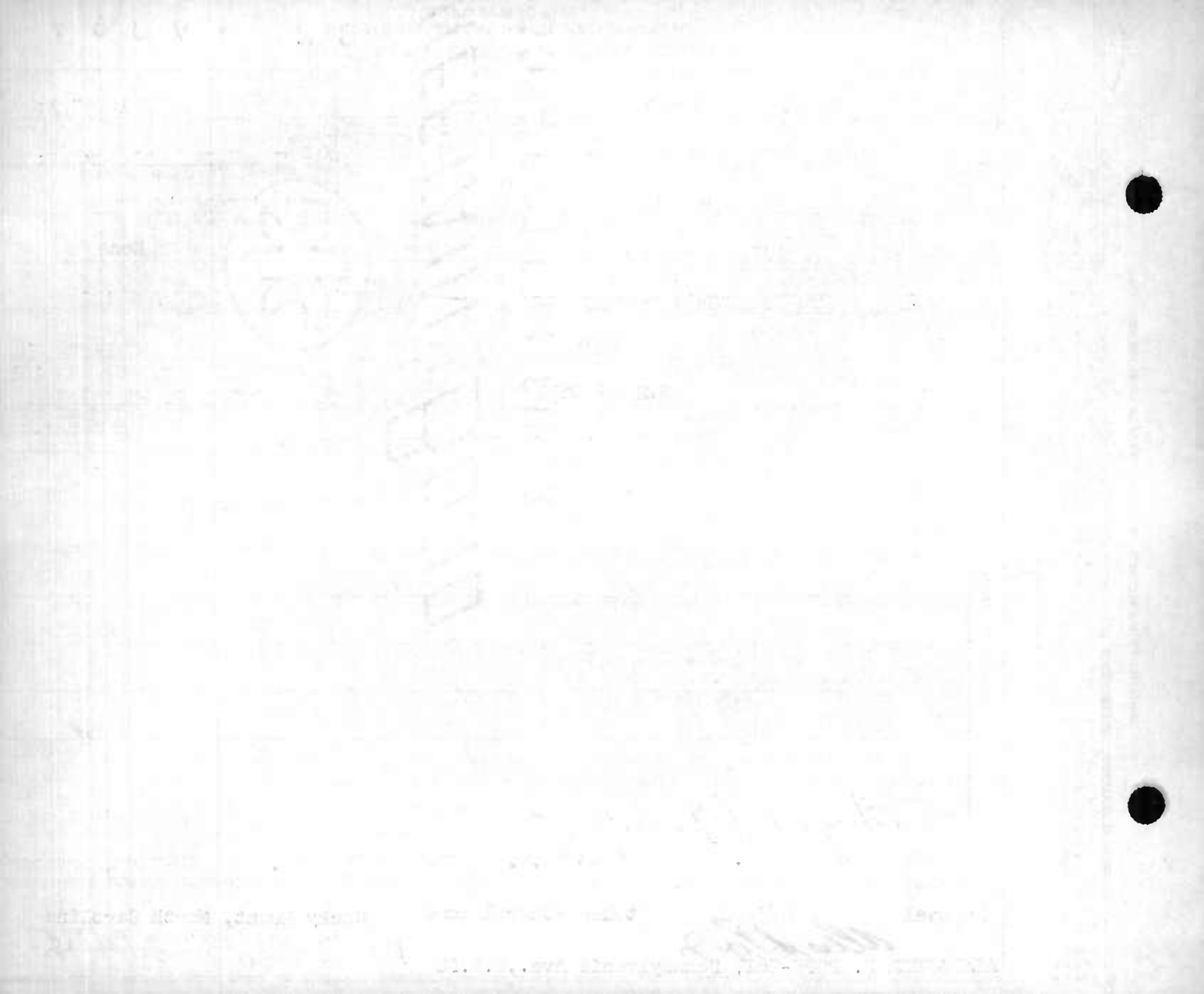
Richard A. Furman, MD

11-8-82  
11-8-82  
11-8-82

JUL 1 1982

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 22 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19069	
1. DECEASED NAME (TYPE OR PRINT) <b>WILLA BEATRICE JOHNSON</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>JULY 31 1982</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH <b>MARCH</b> DAY <b>23</b> YEAR <b>1928</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.	IF UNDER 1 YR. MONTHS _____ DAYS _____	IF UNDER 24 HRS. HOURS _____ MIN _____	2c. DATE PRONOUNCED <b>JULY 31 1982</b>		2d. HOUR <b>3:30 PM</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>ANDREWS AFB</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MALCOLM GROW USAF MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>PRINCE GEORGE'S</b>		13c. CITY OR TOWN <b>FORESTVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3207 WALTERS LANE APT 101</b>			
14. FATHER'S NAME FIRST <b>TYLER</b> MIDDLE <b>A</b> LAST <b>BRANCH</b>				15. MOTHER'S MAIDEN NAME FIRST <b>SARAH</b> MIDDLE <b>J</b> LAST <b>WALKER</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. <b>201 22 9631</b>		17. INFORMANT <b>3207 WALTERS LANE APT 101 WILLIAM JOHNSON FORESTVILLE, MD 20747</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4029 IMMEDIATE CAUSE (a) HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <b>DEPUTY</b>				DATE SIGNED <b>8-1-82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>AUGUSTO P. RODRIGUEZ, M.D.</b>				ADDRESS <b>5009 RAYBURN CT. CAMP SPRINGS, MD 20748</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>8/5/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Stokes Funeral Home</b>			23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____ <b>Rocky Mount, North Carolina</b>				
24. FUNERAL DIRECTOR NAME <i>Alexander S. Pope</i> ADDRESS _____				25a. DATE REC'D. BY REGISTRAR <b>AUG 6 1982</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>					
26. FUNERAL HOME <b>ALEXANDER S. POPE-2617 Pennsylvania Ave., S.E. DC</b>											





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Betty</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 19, 1982</b>			2b. HOUR <b>7:40</b> AM			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 14, 1998</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Missouri</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges Co., MD.</b>			
10. CITY OR TOWN OF DEATH <b>Lanham</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Magnolia Gardens Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House Wife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2300 Calvert St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Julius Goldstein</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Naomi Unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Julian Jolkovsky</b>		ADDRESS <b>2300 Calvert Street Hyattsville Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 mins</b> years									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>May 25</b> , 19 <b>82</b> , to <b>July 19</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>July 14</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Dr. Leon Levitsky</b>			DEGREE			22c. DATE SIGNED <b>July 19, 1982</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Leon Levitsky</b>			22e. ADDRESS <b>3408 Rhode Island Ave. Mt. Rainier</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7-21-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Adelphi P.G. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Warner E. Pumphrey Inc.</b>			24b. ADDRESS <b>Howan Rd, Hale P.O., Box 7428 Slv. Spr. Md</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 21 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James Van Notten</b>	

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19071	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Gladys Ann Jones</b>							2a. DATE KNOWN OF DEATH ESTIMATED <b>7 19 82</b>		2b. HOUR <b>428 AM</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 27, 1914</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>68</b> YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>7 19 82</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4306 Emerson Street, D-5</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Store</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4306 Emerson Street, D-5</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur Meeson</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Hubbard</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>176-20-0586</b>		17. INFORMANT ADDRESS <b>Mr. David W. Jones, Jr. Apt-3 Hyatts, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: <b>hx of ASVD</b> (b) <b>heart stroke</b> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>SAUD A DACE M</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>July 20, 1982</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Said A. Dace, M.D.</b>				ADDRESS <b>5632 Annapolis Road, Suite # 4 Bladensburg, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7-22-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>						25a. DATE REC'D BY REGISTRAR <b>JUL 22 1982</b>					

F. Beach's Sons & Co. L.L. Hyattsville, Md.

Serial 7-22-22 Wt. Lincoln Cemetery Brentwood P.G. Md.

Said A. Dace, M.D.

7033 Annapolis Road, Suite 101  
Hyattsville, Maryland

July 20, 1981

No 178-30-0380 Mr. David W. Jones, 17. Apt-3 Hyattsville, Md.

Arthur Henson William Richard

Maryland P.C. Hyattsville x 4706 Brown Street, D-5

Hyattsville 4706 Brown Street, D-5 Clerk State

Pennsylvania P.C.A.

Female White Feb. 27, 1914 61

Clady Ann Jones

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19072	
1. DECEASED NAME (TYPE OR PRINT) <b>Oscar J. Jordan</b>						2a. DATE KNOWN OF DEATH ESTIMATED <b>July 10, 1982</b>		7b. HOUR <b>11:50 A.M.</b>			
1. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 26, 1901</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>80 YRS.</b>	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>July 10, 1982</b>		7d. HOUR <b>4:30 A.M.</b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Oklahoma</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>15800 Sherwood Avenue</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>				
13a. STATE <b>Maryland</b>				13b. COUNTY <b>P.G. Co.</b>	13c. CITY OR TOWN <b>Laurel</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>15800 Sherwood Avenue</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jasper - Jordan</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia - Wilbanks</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		(IF YES, GIVE WAR OR DATES) <b>1924 - 1927</b>		16b. SOCIAL SECURITY NO. <b>579-34-8743</b>		17. INFORMANT ADDRESS <b>Stanley Jordan (Son) Same as # 13.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4408</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>ASVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Said A. Daee M.D.</b>		TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER		DATE SIGNED <b>July 10/82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Dr. Said A. Daee, M.D.</b>		ADDRESS <b>5632 Annapolis Rd, Suite 4, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>July 12/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, P.G. Co., Maryland</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Chambers Funeral Home Riverdale, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 14 1982</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 9 0 7 3	
FOR 1. STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOSEPH J KELLY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7 1 82</b>		2b. HOUR <b>5:05 AM</b>
3. SEX <b>MALE</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 4, 1898</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY MD.</b>		
10. CITY OR TOWN OF DEATH <b>CLINTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN MARYLAND HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Lawn Maintenance</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US Government</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>St. Mary's</b>	13c. CITY OR TOWN <b>Lexington Pk.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>Coronado Dr. # 37</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alfred Kelly</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Ann Butler</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>228-12-0145</b>		17. INFORMANT ADDRESS <b>Mary Bertha Kelly, Lexington Park, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEVERE CHRONIC OBSTRUCTIVE LUNG DISEASE - YRS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>EMPHYSEMA</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>SEVERE ARTERIAL OCCLUSIVE DISEASE</b>					
19a. DATE OF OPERATION <b>6-16-82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>removal of LAD-P bypass</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 19 82</b> to <b>6-30 19 82</b> , that (I) (we) lost saw the deceased alive on <b>6-30 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Michael G. Seremetis, MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>7-1-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL G. SEREMETIS, MD</b>		22e. ADDRESS <b>3921 Fenwick Dr. Silver Spring, MD 20906</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-6-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Catholic</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hollywood, St. Mary's, Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Brinsfield Funeral Home, Leonardtown, Maryland</b>		ADDRESS <b>25a. DATE REC'D. BY REGISTRAR</b>		25b. REGISTRAR'S SIGNATURE <b>JUL 8 1982</b>	

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Male

Gen.

Sept. 17, 1902

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West Virginia, U.S.A.

x

Plumber

x Highway 2 Box 340

Maryland, Gaithersburg

William H. Kelly Mary Ellis Knight

Yes 210-10-5547 Elsie Kelly born on 17

x



Butler 7-6-82 Trinity Men. Gardens, Gaithersburg, Md.

Hunt Funeral Home, Gaithersburg, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>HERMAN E KENNEY</b>		2a. DATE OF DEATH July 19, 1982		2b. HOUR 1:59a M	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>FEBRUARY 17, 1915</b>	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (In years last birthday) <b>67</b> YRS.	
10. CITY OR TOWN OF DEATH <b>Riverdale</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Leland Memorial Hospital</b>		9. COUNTY OF DEATH <b>Prince George's Md.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>P.G. CO.</b>		13c. CITY OR TOWN <b>LANDOVER HILLS</b>	
14. FATHER'S NAME <b>HERMAN W. KENNEY</b>		15. MOTHER'S MAIDEN NAME <b>EDNA M. THOMPSON</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>YES</b> (If yes give war or dates of service) <b>WWII</b>		16b. SOCIAL SECURITY NO. <b>578-07-8385</b>		17. INFORMANT <b>GLADYS E. KENNEY (WIFE) SAME AS # 13.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4413 Ruptured Abdominal Aneurysm</b> IMMEDIATE CAUSE (a) <b>4413</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <b>7/18/82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ruptured Aneurysm</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>M. D.</b> , 19 <b>80</b> , to _____, 19____, that (I) (we) last saw the deceased alive on <b>7/18/82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>George W. Ware</b>				22c. DATE SIGNED <b>7/19/82</b>	
22d. PHYSICIAN'S NAME (Type) <b>George W. Ware, M. D.</b>				22e. ADDRESS <b>14300 Gahlant Fox Lane, Bowie, Md. 20715</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July/22/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	
24. FUNERAL DIRECTOR <b>Chambers Funeral Home Riverdale, Maryland</b>		23d. LOCATION (City or Town) (County) (State) <b>Brentwood, P.G. Co., Maryland</b>		25a. REC'D BY REGISTRAR <b>JUL 23 1982</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Louise Cadle Kerby</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>07 11 82</b>				
3. SEX <b>Female</b>					2b. HOUR <b>9:10 P.M.</b>				
4. RACE <b>Caucasian</b>					5. DATE OF BIRTH MONTH DAY YEAR <b>July 30 1893</b>				
6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b>					7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS</b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>					7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.				
10. CITY OR TOWN OF DEATH <b>Clinton</b>					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital</b>				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>				
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Pr. George</b>				
13c. CITY OR TOWN <b>Ft. Washington</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13e. STREET ADDRESS <b>9301 Livingston Road</b>									
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Cadle</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice Pyles</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>					16b. SOCIAL SECURITY NO. <b>577-68-8338</b>				
17. INFORMANT <b>Lindy A. Kerby</b>					ADDRESS <b>9215 Livingston Road Ft. Washington, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>5789 Cardiorespiratory Failure</b> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) <b>Gastrointestinal Bleeding</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Dehydration</b> DUE TO, OR AS A CONSEQUENCE OF <b>2-3 days</b> <b>2-3 days</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>				
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) <del>this hospital</del> attended the deceased from <b>6 Oct 72</b> to <b>7-11-82</b> ; that (1) <del>was lost</del> saw the deceased alive on <b>7-10-82</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above; (1) <del>did</del> (did not) view the body after death.									
22b. SIGNATURE <b>David N. Robb MD</b>					22c. DATE SIGNED <b>7-12-82</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David N. Robb, M.D.</b>					22e. ADDRESS <b>9401 Indian Head Highway Ft. Washington, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>7/14/82</b>				
23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Epis. Ch. Cem</b>					23d. LOCATION CITY OR TOWN COUNTY STATE <b>Broadcreek P.G. Maryland</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>George P. Kalas Funeral Home</b>					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JUL 16 1982</b>				

David W. Robb, M.D.  
1411 Washington, Maryland  
Shelton Indian Head Highway

George F. Kulas  
St. John's Hotel, Ch. New Brunswick, N.J.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>John C Kern</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 6, 1982</b>		2b. HOUR <b>6:10 AM</b>
3. SEX <b>MALE</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6 04 94</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Reading, Pa.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>US</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges CO MD.</b>		
10. CITY OR TOWN OF DEATH <b>Forestville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Regency, Nursing &amp; Rehab - Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Machinist Bur.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>of Engraving</b>
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>MD</b>	13b. COUNTY <b>P. S</b>	13c. CITY OR TOWN <b>Forestville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>7420 Marlboro Pike</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles V. Kern</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Hafer</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>677-604114</b>	17. INTERMENT <b>2700 30th St. S.E. #B339 Wash. D.C. 20020</b> <b>Vicki J. Clark personal representative</b>		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>C.V.A. (Cerebral vascular accident)</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>5-13</b> , 19 <b>82</b> , to <b>7-6</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>7-1</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>William Isont Furst</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/6/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William Isont Furst</b>		22e. ADDRESS <b>9401 Indian Hill Highway Over Hill MD</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>July 10, 1982</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Charles Evans Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Reading, Pa</b>
24. FUNERAL DIRECTOR NAME <b>Lee Funeral Home</b>		25. REG. BY REGISTERED PROFESSIONAL SIGNATURE <b>JUL 13 1982</b>	
300-4th St. N.E. Wash. D.C. 20002			

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(continued on next page)

Environ

July 10, 1952 Charles Evans Cessford, Jr.,

JAN 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>ROSE</b>			FIRST <b>M.</b>			MIDDLE <b>KERWIN</b>			LAST			2a DATE OF DEATH MONTH DAY YEAR <b>JULY 30, 1982</b>				2b HOUR <b>8:45 A</b> M		
3 SEX <b>Female</b>			4 RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>May 28 1902</b>			6 AGE (IN YEARS LAST BIRTHDAY) <b>80</b>			IF UNDER 1 YEAR MONTHS DAYS <b>YRS</b>		IF UNDER 24 HRS HOURS MIN.				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>			7b CITIZEN OF WHAT COUNTRY? <b>USA</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.									
10 CITY OR TOWN OF DEATH <b>Hyattsville</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Home</b>						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Contract Adm.</b>				12b KIND OF BUSINESS OR INDUSTRY <b>Navy Dept.</b>					
13a STATE <b>Maryland</b>			13b COUNTY <b>Pr. Georges Mt. Rainier</b>			13c CITY OR TOWN <b>NO</b>			13d INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			13e STREET ADDRESS <b>3228 Chillum Road,</b>						
14 FATHER'S NAME FIRST MIDDLE LAST <b>Frank</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose McCrossen</b>			ADDRESS <b>13125 Wellford Dr</b>												
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>--</b>			17 INFORMANT <b>James J. Kerwin-son-Beltsville, Md.</b>			ADDRESS <b>13125 Wellford Dr</b>									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY <b>1729</b> IMMEDIATE CAUSE (a) <b>Central Nervous System Metastases</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Melanoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>24 years</b>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>few months</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):																		
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE												
22a I certify that (I) (this hospital) attended the deceased from <b>August 19 81</b> to <b>July 30 19 82</b> , that (I) (we) last saw the deceased alive on <b>July 26 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) (did not) view the body after death.																		
22b SIGNATURE <b>G. Lenard Gold, M.D.</b>															DEGREE		22c DATE SIGNED <b>7/30/82</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. LENARD GOLD</b>															22e ADDRESS <b>8630 FENTON ST. SILVER SPRING, MD.</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>8-3-1982</b>			23c NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			23d LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Virginia</b>									
24 FUNERAL DIRECTOR NAME ADDRESS <b>Hines/Rinaldi Funeral Home S.S. Md.</b>																		
DATE REC'D. BY REGISTRAR <b>AUG-4 1982</b> REGISTRAR'S SIGNATURE <b>Frances San Nathan</b>																		



1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST FRANCIS		MIDDLE G.		LAST KILLIAN		2a. DATE OF DEATH MONTH DAY YEAR 07-19-82		2b. HOUR 5:22PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 25, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		7a. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD						
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Pepco			
13a. STATE Maryland				13b. COUNTY P.G.		13c. CITY OR TOWN Mt. Rainier		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4609 29th. Street Apt-1		
14. FATHER'S NAME FIRST MIDDLE LAST Calvin Killian				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Ward								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes - W.W.II				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Coast Guard		17. INFORMANT Mary E. Wilson		ADDRESS 115 Geneva Ave. Westmont, New Jersey				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5789 ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (c) GASTRO INTESTINAL BLEEDING Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CELLULITIS RIGHT LEG, DIABETES MELLITUS.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 7.16. 19. 82, to 7.19. 19. 82, that (I) (we) lost saw the deceased alive on 7.19. 19. 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE V.P. Singh				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7.20.82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V.P. Singh				22e. ADDRESS 6490 LANDOVER RD. LANDOVER MD 20785								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 22, 1982		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS F. Gasch's Sons F.H. P.A. Hyattsville, Md.						25a. DATE REC'D. BY REGISTRAR JUL 22 1982						
						25b. REGISTRAR'S SIGNATURE Frances Jan Nathan						

F. Casch's Sons P.H. P.L. Westerville, Md.

Burial July 22, 1982 Cedar Hill Cemetery Baltimore P.O. Maryland

x

Yes - W.V.I. Coast Guard 570-03-0282 Mary E. Wilson Westmont, New Jersey

Calvin William Pearl

Maryland W.D. Mt. Rainier x 1800 20th Street Apt-1

CLEVELY PRINCE GEORGE'S GENERAL HOSP. Retired

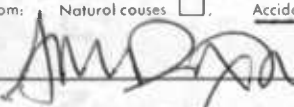

North Carolina U.S.A. x

Male White

June 25, 1906

78

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19080	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>TRACY Robert KING</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>7 30 1982</b>	
3. SEX <b>Male</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 6, 1961 21 YRS.</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>7 30 1982</b>		2b. HOUR <b>5:24</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D.C.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Accokeek</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>16604 Bealle Hill Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance Man</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Gardening</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>			13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Accokeek</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>16614 Bealle Hill Road</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Donald R. King</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annabelle F. Crampton</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>212-86-0011</b>		17. INFORMANT ADDRESS <b>Annabelle F. Corbin same as 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> 9102 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. 7-30- 19 82</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Drowned in swimming pool.</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>swimming pool</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>16604 Bealle Hill Rd., Accokeek, Prince George's County, Md.</b>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>M.D. Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>7-31-82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>				ADDRESS <b>111 Penn St., Balto., Md. 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8-3-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Mem. Gardens</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waldorf, Charles, Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Huntt Funeral Home, Waldorf, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 4 1982</b>		25b. REGISTRAR 			



admit

Date Jan. 6, 1961

U.S.A.

Postage Paid

Postage Paid (1) 1961

Postage Paid (1) 1961

Postage Paid (1) 1961

1961



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) <b>Joseph Elmer Knott</b>					2a. DATE KNOWN OF DEATH ESTI- MATED <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>7 24 82</b>				
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>10</b> DAY <b>14</b> YEAR <b>22</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>60</b> YRS.		7b. HOUR <b>11AM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Chaptico, Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b>	
10. CITY OR TOWN OF DEATH <b>Cheverly</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7736 Fredrick west lane</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>Md.</b>				13b. COUNTY <b>Prince George</b>		13c. CITY OR TOWN <b>Landover Hills</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
14. FATHER'S NAME FIRST <b>James Harry</b> MIDDLE <b>Knott</b> LAST				15. MOTHER'S MAIDEN NAME FIRST <b>Alice Elizabeth</b> MIDDLE <b>Thompson</b> LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Eva C. Knott</b> ADDRESS <b>4600 Riverdale Rd. Riverdale, Md. 20737</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>5715</b> IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>Emphysema</b> (b) <b>Emphysema</b> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <b>Said A. DARR M</b>				23. DATE <b>July 27, 1982</b>				23b. NAME OF CEMETERY OR CREMATORY <b>Charles Memorial Gardens Leonardtown St. Marys</b>	
EXAMINER'S NAME (TYPE OR PRINT)				23c. LOCATION CITY OR TOWN COUNTY STATE				23d. DATE REC'D. BY REGISTRAR <b>JUL 28 1982</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>July 27, 1982</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Charles Memorial Gardens Leonardtown St. Marys</b>	
24. FUNERAL DIRECTOR NAME <b>W. Clarke Mattingley</b> ADDRESS <b>Leonardtown, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 28 1982</b>				25b. REGISTRAR'S SIGNATURE <b>James J. Mattingley</b>	

10000

091111

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 9 0 8 2			
FOR 1. STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR HOUR			
WILBUR LEDRU KOONTZ				07 01 82 12:20 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		Caucasian		March 26 1902		80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Washington, D.C.		U.S.A.				Prince Georges MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Clinton		Southern Maryland Hospital Center		Banker - Retired		Banking	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
Maryland				Pr. George		Clinton	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
William L. Koontz				Irene E. Pyles			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT	
No				577-09-0591A		Carolyn K. Arban	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 4350 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Vertebral Basilar Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-1 19 82, to 7/1 19 82, that (I) (last) saw the deceased alive on 7-1 19 82, and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above, (I) (last) (did) (not) view the body after death.		22b. SIGNATURE C. C. Colao		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/2/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles Colao, M.D.		22e. ADDRESS 3710 Riviera St., Marlow Heights, Md. 20748					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/6/82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Georges, Maryland	
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home				25a. DATE REC'D. BY REGISTRAR JUL 8 1982			

George F. Kaiss Funeral Home Oxon Hill, Md.  
 6100 Oxon Hill Rd.  
 Oxon Hill Cemetery  
 Oxon Hill, Md.  
 7/6/82  
 Burial

William I. Koontz Irene E. Lyles  
 6109 Den Lee Dr. N. E. Lyles  
 6109 Den Lee Drive  
 Maryland Ex. George Clinton x  
 Washington, D.C. U.S.A. x  
 Male  
 Caucasian  
 March 26 1905  
 80

LEWIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 9 0 8 3		
1- FOR STATE REGISTRAR			CERTIFICATE OF DEATH								REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR			
MARY AGNES KUZIO			JULY 20 1982			7:50P			M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female		White		August 12, 1903		78 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Pennsylvania		U.S.A.				Prince George's MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Lanham		Doctors' Hospital of Pr. Geo. Co.				Housewife		Own Home				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland			P.G.		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7406 Jefferson Street			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
George			Marco			Elizabeth			Marcinask			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No			161-50-2395		Mr. James H. Evans 347 South 2nd. St. St. Clair, Pennsylvania							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Septicemia, Cerebrovascular accident.</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) _____												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
			P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (I) (this hospital) attended the deceased from <u>7-16-1982</u> to <u>7-20-1982</u> that (I) (we) last saw the deceased alive on <u>7-20-1982</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			DEGREE <u>MD.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
									7/21/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									
MUSHTAQ A. SHAH			4637 Eastern Avenue,									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			July 24, 1982		Immaculate Conception Cem.			St. Clair Schuyhill, Pa.				
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
F. Gasch's Sons F.H. P.A. Hyattsville, Md.						JUL 23 1982						

No	101-50-2308	Mr. James H. Evans	St. Clair, Pennsylvania
George	Harco	Elizabeth	Harco
Maryland	P.O.	Hyattsville	7400 Jefferson Street
Tennessee	U.S.A.	x	Housewife
Female	White	August 12, 1903	Own home

7. Inach's sons W.H. & J. Hyattsville, Md.  
 Burial July 24, 1903 Immaculate Conception Cem. St. Clair Schuylkill Co. Pa.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3. THIS FORM IS TO BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, AND 3 SHOULD BE FILED, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)						FIRST MIDDLE LAST						2a. DATE KNOWN OF DEATH		2b. HOUR			
Lelia C. Ladd												X MONTH DAY YEAR		11.45 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR			
Female		White		Feb. 23, 1897		85 YRS.		MONTHS DAYS		HOURS MIN.		July 5, 1982		4 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED				9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia				U.S.A.				WIDOWED X NEVER MARRIED DIVORCED				Prince George's County MD					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
College Park				7503 Citadel Drive				Housewife				Own Home					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		P.G.		College Park		YES X NO		7503 Citadel Drive									
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST						FIRST MIDDLE LAST											
Dabney C. Chandler						Julia Proffit											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS					
No						212-74-9917						Mrs. Frances L. Willis No# 13e.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY:																	
1519 IMMEDIATE CAUSE (a) Cardio respiratory arrest																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b) Carcinoma of Stomach																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
												YES NO X					
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH						21b. TIME OF INJURY						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
						HOUR A.M. MONTH DAY YEAR											
						P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION					
												STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes X Accident, Suicide, Homicide, Undetermined manner.																	
ACTUAL SIGNATURE						TITLE (SPECIFY)						DATE SIGNED					
Said A. Daee, M.D.						M.D. Deputy						July 5, 1982					
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS											
Said A. Daee, M.D.						5632 Annapolis Rd. Suite #4-Blad. Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial						July 7, 1982		Grace Epis. Ch. Cemetery Cismont				Albemarle Va.					
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE					
F. Gasch's Sons F.H. P.A. Hyattsville, Maryland						JUL 9 1982											

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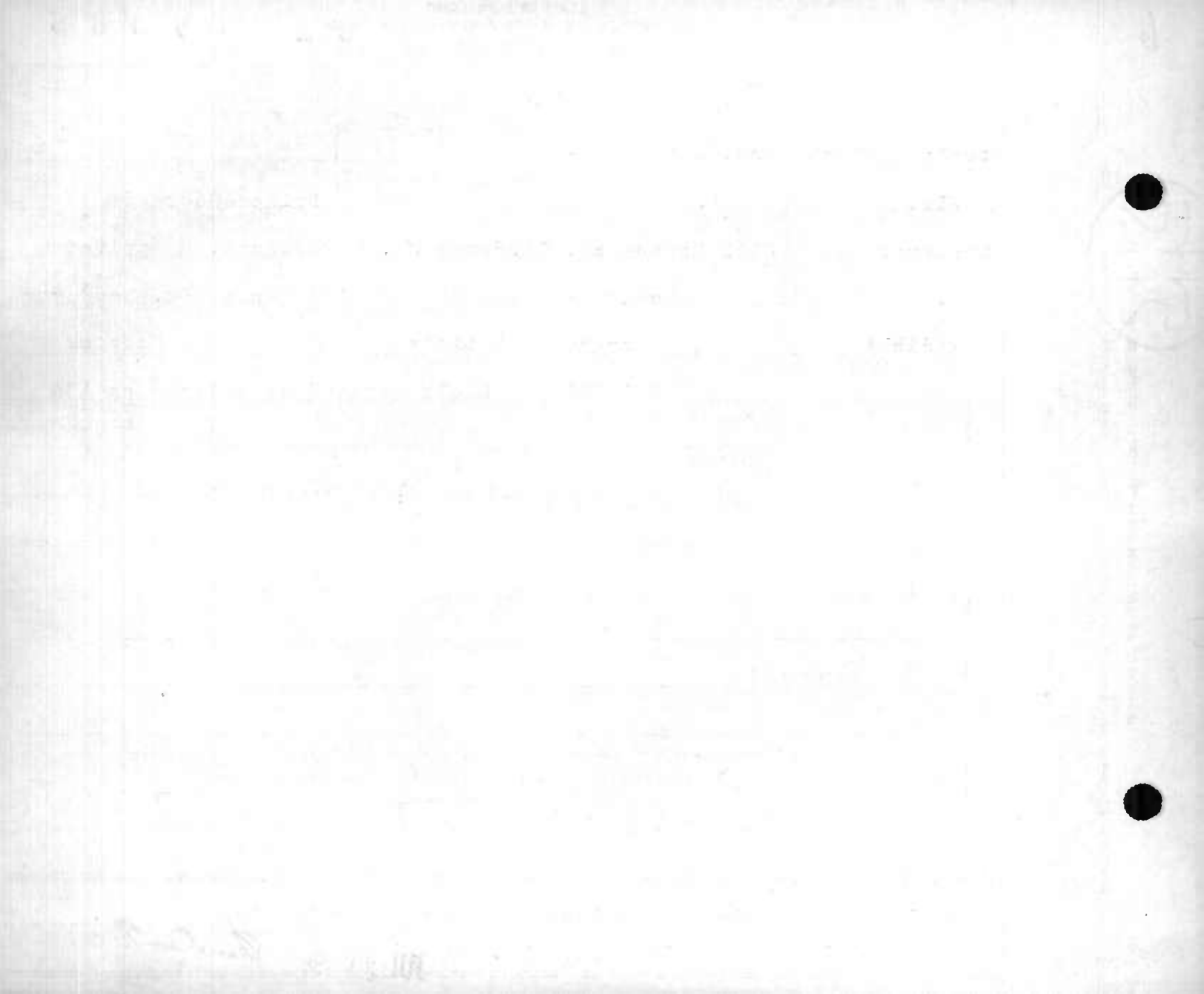
TABLE 2. *Continued*

...continued

7. Geschlechtsunterschiede

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										19085	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Paullette</b> <b>Lampkin</b>										2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN. <b>7 22 82 10 PM</b>	
3. SEX <b>Female</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 4, 1952</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>29 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>7 22 82 23</b>	7d. HOUR <b>PM</b>		7e. HOUR <b>PM</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Fla.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b>		MD.			
10. CITY OR TOWN OF DEATH <b>Landover</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8113 Manson St. Landover Md. Nurse Asst.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>private</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Landover</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8113 Manson St. Landover</b>		Md.	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Obidiah Morgan</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Liola Webster</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>261085308</b>		17. INFORMANT <b>Liola Morgan (mother)</b>				ADDRESS <b>same as 13e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>2028</b> IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>advanced lymphoma</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>SAD A. DARIE MD</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER		DATE SIGNED <b>7-22-82</b>	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>				23b. DATE <b>7-26-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cheltenham Veterans</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cheltenham Md.</b>			
24. FUNERAL DIRECTOR NAME <b>FRAZIER'S</b>				ADDRESS <b>389 R.I. AVE. NW</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 30 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James G. [Signature]</b>	

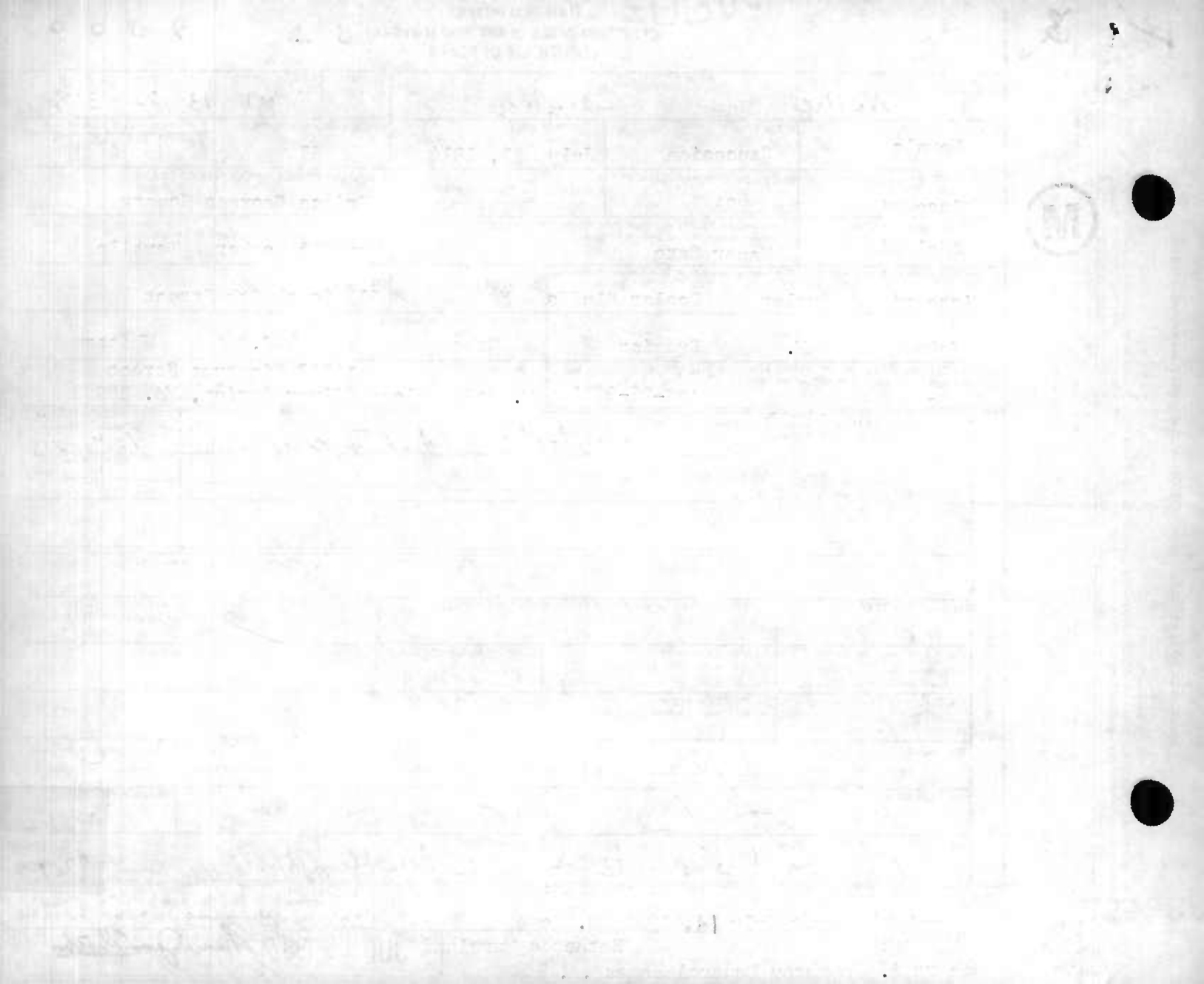


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.									
1. FOR STATE REGISTRAR					2r. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR						
1 DECEASED NAME (TYPE OR PRINT)					FIRST		MIDDLE		LAST		07		13 82 315 P M						
Nellie Mae Langley																			
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			7 UNDER 1 YEAR							
Female			Caucasian			July 23, 1914			67 YRS			MONTHS DAYS HOURS MIN.							
7r. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH										
Missouri			USA						Prince Georges County MD.										
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12r. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Adelphi			Manor Care			Textile Worker			Textile										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. CITY OR TOWN					13b. INSIDE CITY LIMITS?					13c. STREET ADDRESS				
13a. STATE					13b. COUNTY					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					512 South 9th Street				
Missouri					Butler					Poplar Bluffs									
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME														
FIRST MIDDLE LAST					FIRST MIDDLE LAST														
John M. Frazier					Etha J. Whitton														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO					17 INFORMANT					11727 Ringtree Street				
No					495-28-0929					M. Otis Delong Silver Spring, Md. 20902									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY:																			
4100 IMMEDIATE CAUSE (a) <u>Auto Myocardial Infarction</u>													10 Minutes						
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
				HOUR A.M. MONTH DAY YEAR															
				P.M. 19															
21d. INJURY OCCURRED				21r. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21i. LOCATION											
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>								STREET				CITY OR TOWN COUNTY STATE							
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>																			
22a. I certify that (i) (this hospital) attended the deceased from <u>17 Aug</u> 19 <u>82</u> , to <u>13 Aug</u> 19 <u>82</u> , that (i) (we) last saw the deceased alive on <u>13 Aug</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED							
												13 Aug 82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS															
Michael Leibowitz				11120 New Hampshire Ave SE, Washington															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Burial/Transit				July 14, 1982				Mt. Hope				LeMay Missouri							
24 FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Robert A. Pumphrey				Funeral Homes P.A.				Bethesda Maryland				JUL 19 1982							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 9 0 8 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST <b>MELBA LUCILLE LAPHEW</b>				MONTH DAY YEAR <b>07 12 82</b>			
3. SEX <b>Female</b>				2b. HOUR <b>6:00A.M.</b>			
4. RACE <b>Caucasian</b>				5. DATE OF BIRTH MONTH DAY YEAR <b>August 11 1920</b>			
6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b>				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.			
10. CITY OR TOWN OF DEATH <b>Clinton</b>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital</b>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Government - Ret.</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Fed. Gov't.</b>			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Prince George Silver Hill</b>			
13c. CITY OR TOWN <b>Silver Hill</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS <b>3415 Bonita Street</b>				14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur G. Byrd</b>			
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruth Tilghman</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>237-12-9441</b>				17. INFORMANT ADDRESS <b>4807 Mori Drive Rockville, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke</b> 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cardiac vascular dis -</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>years</b> <b>year</b>				PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. <b>COPD</b>			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				21d. LOCATION STREET CITY OR TOWN COUNTY STATE			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1974</b> to <b>7-12-82</b> , that (I) (we) last saw the deceased alive on <b>7-12-82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE <b>Daniel Howell</b>			
22c. DATE SIGNED <b>7-12-82</b>				22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Daniel Howell, M.D.</b>			
22e. ADDRESS <b>Charles Professional Bldg. Waldorf, Md. 20601</b>				22f. SIGNATURE <b>Charles</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>7/14/82</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Pr. Geo. Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>George P. Kalas Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 16 1982</b>			
25b. REGISTRAR'S SIGNATURE <b>James K. Nathan</b>				25c. REGISTRAR'S NAME <b>James K. Nathan</b>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					8 2 1 9 0 8 8				
CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>SARAH J. LAUZIERE</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>07-02-82</b>			2b. HOUR <b>2:19AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8-12-00</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY MD</b>			
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) <b>PRINCE GEORGE'S GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5805 42nd Ave.</b>	
14. FATHER'S NAME <b>Nicholas</b> MIDDLE <b>Brookman</b>					15. MOTHER'S MAIDEN NAME <b>Sarah</b> MIDDLE <b>Henderson</b> LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212 24 4377</b>		17. INFORMANT <b>James Lauziere</b> ADDRESS <b>6805 Clowser Crt. Springfield Va.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Bladder carcinoma with metastases.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastases.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>metastases.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>6/12</b> , 19 <b>82</b> , to <b>7/2</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>7/1</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (I) (did not) view the body after death.									
22b. SIGNATURE <b>S. Kumar</b>		22c. DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d. DATE SIGNED <b>7/2/82</b>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. KUMAR, M.D.</b>				22f. ADDRESS <b>3726 Rhode Island Av Brentwood, Md. 20722.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/6/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. MD</b>			
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. Riverdale Md.</b>				25a. DATE RECEIVED BY REGISTRAR <b>JUL 8 1982</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1. STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 1 9 0 8 9	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		7a. DATE OF DEATH MONTH DAY YEAR	
Robert		Leeper, Jr.		07 22 82 10:00A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Male	Caucasian	10 28 95		86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Pennsylvania	USA			Prince George's County, MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Camp Springs, Md.	home - 6421 White Oak		Retired Pattern Maker		U.S. Govt.
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
Maryland	Pr. George's	Camp Springs		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS	
Robert Leeper		Mary Doughrty		6421 White Oak Avenue	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT		
Yes		WWI	6421 White Oak Avenue		
		264 64 6458T	Lidie Vaden Camp Springs, Maryland 20748		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Parkinson's Disease; Arteriosclerotic heart disease, Bilateral ischemic ulcers of heels</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atonic, neurogenic bladder</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>diabetes mellitus</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <u>(L) sided hemiparesis due to Cerebral atherosclerosis</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>August 8, 1978</u> to <u>July 22, 1982</u> , that (I) (we) last saw the deceased alive on <u>June 10, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.					
22b. PHYSICIAN'S NAME (TYPE OR PRINT)				22c. DATE SIGNED	
R. A. McConnaughy, M. D.				7/22/82	
22d. ADDRESS				22e. DATE RECEIVED BY REGISTRAR	
5618 St. Barnabas Road, Oxon Hill, Md. 20745				JUL 27 1982	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Cremation		July 22, 1982	Lee's Crematory		Washington, DC
24. FUNERAL DIRECTOR NAME				25a. DATE RECEIVED BY REGISTRAR	
Lee Funeral Home, Inc.				JUL 27 1982	
6638 Old Alexander Ferry Road, Clinton, Maryland				James J. Nathan	



## MEDICAL EXAMINER NOTIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be made.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 9 0 9 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) CHESTER LEWIS				2a. DATE OF DEATH MONTH DAY YEAR 07-25-82		2b. HOUR 12:10 AM	
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 11 29 02		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD			
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Porter		12b. KIND OF BUSINESS OR INDUSTRY G.W. University	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C.		13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 520 Jefferson St. N.E.	
14. FATHER'S NAME FIRST MIDDLE LAST Marshall		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Pryor					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-05-4802		17. INFORMANT ADDRESS Chester Lewis Jr. 4605 Clay St. N.E. Washington, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1519 IMMEDIATE CAUSE (a) <u>Cardiac pulmonary failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastasis of stomach carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Anemia</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/25</u> 19 <u>82</u> to <u>7/25</u> 19 <u>82</u> that (I) (we) last saw the deceased alive on <u>7/25</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Meigh H. Ko</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/25/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MEIGHAN H. KO		22e. ADDRESS PSGM, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/29/82		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Prince Georges MD	
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019				25a. DATE REC'D. BY REGISTRAR AUG 3 1982			

UNITED STATES DEPARTMENT OF JUSTICE

Label

7/1/50

Lincoln Memorial

Witness

Office

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11-11-83 BY SP-5 JAC/STP

EX-100

RECEIVED

NOV 11 1950

WASHINGTON, D.C.

U.S. DEPT. OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ethel L. Linsley			2a. DATE OF DEATH MONTH DAY YEAR July 23, 82		2b. HOUR 9:15 AM
3. SEX Female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 5 JUL 1898	6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD		
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Gardens Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor-Cafeteria		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Mitchellville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3805 Clairton Dr.
14. FATHER'S NAME FIRST MIDDLE LAST Mac Rupard		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachel Taylor			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-18-9037		17. INFORMANT ADDRESS Virginia Rupard Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ① Multiple CVA's 4360 DUE TO, OR AS A CONSEQUENCE OF (b) ② senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ③ diabetes mellitus					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) scattered ulcers					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10.24.1976 to 7.23.82 that (I) (we) lost saw the deceased alive on 7.22.82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE H. A. Mopavi, M.D.		DEGREE M.D.		22c. DATE SIGNED 7-28-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. A. Mopavi, M.D.		22e. ADDRESS 6005 Landover Rd Cheverly Md 20781			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 7-24-82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	
23d. LOCATION CITY OR TOWN Brentwood		23e. COUNTY Prince George's Md.			
24. FUNERAL DIRECTOR NAME Beall Funeral Home		ADDRESS 16,000 Annapolis Rd. Bowie, Md.		25. DATE REC'D. BY REGISTRAR JUL 28 1982	



L.

Prince George

U.S.A.

Virginia

Wagon 1 Garden Nutsingone 2 Service-Center

Mr. P. Geo. Mitchell x 1205 Clifton Dr.

Mr. Robert R. G. T. 1205 Clifton Dr.

No. 1205 Clifton Dr. Virginia Route 8 to 13

Chem. tion 7-24-82 Ft. Lincoln  
3rd I. Funeral Home  
16,000 Ann. Police Rt. Bowie, Md.  
Brentwood, P. Geo. Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - FOR STATE REGISTRAR					7 2 1 9 0 9 2				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
JOSEPH (N.M.I.) LOTTO					07-25-82				
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Male		White		March 19, 1904		78		8:25PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Italy		U.S.A.				PRINCE GEORGE'S COUNTY MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CHEVERLY		PRINCE GEORGE'S GENERAL HOSP.				Barber		Self-Employed	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. CITY OR TOWN				
Maryland P.G.					Cheverly				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Unknown					Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]					16b. SOCIAL SECURITY NO.				
No					218-24-0357				
17. INFORMANT					ADDRESS				
Mrs. Mary A. Lotto					Address Same as No# 13c.				
18 CAUSE OF DEATH (Enter only one cause per line. Do not use "I" or "D" for immediate cause.)									
PART I. DEATH WAS CAUSED BY: <i>4151</i> <i>Bilateral pulmonary embolism</i>									
IMMEDIATE CAUSE (a) <i>Thrombosis, venous</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Thrombosis, venous</i>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Tuberculosis, pulmonary; poliomyelitis, old.</i>									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF OTHER, NOTE MEDICAL EXAMINER)									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR									
21c. HOW INJURY OCCURRED (ENTER IN DETAIL IN ITEM 11 OR PART 2)									
21d. INJURY OCCURRED WHERE AT WORK <input type="checkbox"/> NOT WHERE AT WORK <input checked="" type="checkbox"/> <i>In front of home</i>									
21e. PLACE OF INJURY (LABORATORY, FACTORY, OFFICE, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from <i>7/25/82</i> to <i>July 25 19 82</i> and that (2) <i>apart</i> <i>55</i> <i>July 25 19 82</i> that (3) <i>apart</i> <i>55</i> <i>July 25 19 82</i> saw the deceased alive on <i>7/25/82</i> and that (4) <i>apart</i> <i>55</i> <i>July 25 19 82</i> opinion death occurred on the date and hour and from the causes stated above. (1) (yes) (2) (no) (3) (yes) (4) (no)									
22b. SIGNATURE									
22c. PHYSICIAN'S NAME (TYPE OR PRINT)									
22d. ADDRESS									
22e. DATE SIGNED									
22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)									
23b. DATE									
23c. NAME OF CEMETERY OR CREMATORY									
23d. LOCATION CITY OR TOWN COUNTY STATE									
24 FUNERAL DIRECTOR NAME									
25a. DATE REC'D. BY REGISTRAR									
25b. REGISTRAR'S SIGNATURE									

F. Gasch's Sons F.H. P.A. Hyattsville, Md.

JUL 29 1982

JUL 29 1982

F. Gach's Sons P. H. P. A. Waterville, Me.

Serial July 28, 1983 Ft. Lincoln Cemetery Brentwood N. T. Maryland

James H. Gach  
P.O. Box 100  
Waterville, Me.  
July 28, 1983

James H. Gach  
P.O. Box 100  
Waterville, Me.  
July 28, 1983

No 218-24-0277 Mrs. Mary A. Latta  
Unknown  
Maryland  
T. G.  
Cheverly  
x  
3405 63rd. Road  
Barber  
Self-employed  
Italy  
U.S.A.  
White  
March 10, 1904  
x  
78

(7.1.1.)  
L.H.  
17-23-25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 9 0 9 3			
FOR 1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Mary Reese Lynn</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>July 8, 1982</b>		2b. HOUR <b>11:45A M</b>	
3. SEX <b>Female</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 6 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD.	
10. CITY OR TOWN OF DEATH <b>Forestville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Regency Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Prince George</b> 13c. CITY OR TOWN <b>Temple Hills</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2322 Kenton Place</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lewis S. Reese</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine T. Murphy</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578-10-1570</b>		17. INFORMANT ADDRESS <b>James B. Lynn 28 Mel Mara Drive Oxon Hill, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4140</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 mos.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>Diabetes mellitus</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>December 19 81</b> to <b>July 8 19 82</b> , that (I) (we) last saw the deceased alive on <b>June 24 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>J. Sanford Young</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/8/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. Sanford Young, M.D.</b>				22e. ADDRESS <b>9401 Indian Head Highway Ft. Washington, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/10/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Md.</b>	
24. FUNERAL DIRECTOR NAME <b>G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>1 2 1982</b> <i>James J. [Signature]</i>			

11:55A

July 8, 1982

Lynn

Heese

Very

78

March 6 1904

March 6 1904

Canc.

Female

Prince George

x

USA

Washington, D.C.

at home

Honolulu

Agency running home

Forestville

2025 Newton Place

x

Prince George Temple Hills

Maryland

Murphy

T.

Josephine

Heese

B.

Lewis

28 West Main Drive

Oxon Hill, Maryland

James R. Lynn

78-10-170

No

9101 Indian Head Highway  
Ft. Washington, Maryland

J. Sanford Young, 1.1.1.

14.

Greenwood

Ft. Lincoln Cemetery

7/10/82

Revised

O.E. Kates 6160 Oxon Hill Rd. Oxon Hill, Md.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 27 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item #7a per phone call w/Fun. Home STATE OF MARYLAND  
FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
1- STATE 7/30/82 rc MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
REG. NO. 19094

1. DECEASED NAME (TYPE OR PRINT) <b>John Coyle MacDonald.</b>		2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY 7 YEAR 1982		2b. HOUR AM	
3. SEX <b>Male.</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH 1 DAY 26 YEAR 1938	6. AGE (IN YEARS) LAST BIRTHDAY 44 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Michigan Kentucky</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George County</b>		10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>630 Sheradon Street/ Lobby</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Meter Reader</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>V.E.P., Co</b>		13a. STREET ADDRESS <b>630 Sheridan St. Apt. 212</b>	
13b. STATE <b>Maryland</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Nicholas C. MacDonald</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Killoran</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>	
16b. SOCIAL SECURITY NO. <b>577-52-6322</b>		17. INFORMANT ADDRESS <b>Douglas D. MacDonald Altamonte Spr's Florida.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of chest</b> Weapon: <b>Unspecified</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5:30 AM 7/26 1982</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject shot</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>lobby</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>630 Sheradon Street, Hyattsville, PG Co, MD</b>	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>		TITLE (SPECIFY) <b>Assistant</b>		DATE SIGNED <b>7/26/82</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>		ADDRESS <b>111 Penn Street, Balto. MD 21201</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/30/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Louis Cemetery</b>	
23d. LOCATION CITY OR TOWN <b>Louisville, Kentucky.</b>		23e. COUNTY <b>Kentucky</b>		23f. STATE <b>Kentucky</b>	
24. FUNERAL DIRECTOR <b>Takoma Funeral Home Inc</b>		24a. ADDRESS <b>254 Carroll St. N. W.</b>		24b. DATE REC'D. BY REGISTRAR <b>JUL 29 1982</b>	

BP



MacDonald.

Male, White 1/30/1982 44

Kentucky U. S. A.

Master Reader V.M.F., Co

Maryland Trin. Georgetownville x 630 Sheridan St. 212

Nicholas G. MacDonald Mary Killoran

577-52-6322 Douglas D. MacDonald Florida Alamo Heights

Burial 7/30/1982 St. Louis Cemetery Louisville, Kentucky.  
Takoma Funeral Home Inc.  
224 Carroll St. N. W. D. C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

19095

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Ruth

MALE

2a. DATE KNOWN  
OF DEATH  
ESTIMATED  
MONTH DAY YEAR

7-29-82

2b. HOUR

M

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH  
MONTH DAY YEAR

5-4-14

6. AGE (IN YEARS)  
LAST BIRTHDAY  
YRS.

68

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

7c. DATE  
PRONOUNCED  
DEAD  
MONTH DAY YEAR

7-29-82

24 HOUR  
M7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

Pa.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince Georges

MD.

10. CITY OR TOWN OF DEATH

Ft. Washington

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

8007 Murray Hill Drive

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

Homemaker

12b. KIND OF BUSINESS  
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

PG

13c. CITY OR TOWN

Ft. Washington

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e. STREET ADDRESS

8007 Murray Hills Drive

14. FATHER'S NAME

FIRST

MIDDLE

LAST

Frank

Spangenberg

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Lottie

Jenkins

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

179-09-1370

17. INFORMANT

Same as Above  
Walter M. Male, Husband

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4292

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR  
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an

Autopsy ☐Inspection ☒Inquiry ☒

and in my opinion

death resulted from: Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐ACTUAL  
SIGNATURE

Augusto P. Rodriguez

TITLE (SPECIFY)

Deputy

MEDICAL EXAMINER

DATE  
SIGNED

7-30-82

EXAMINER'S NAME  
(TYPE OR PRINT)

Augusto P. Rodriguez M.D.

ADDRESS

5009 Rayburn Ct., Temple Hills, Md.

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

7-31-82

23c. NAME OF CEMETERY OR CREMATORY

Ft. Lincoln Cem.

23d. LOCATION  
CITY OR TOWN

Brentwood, P.G., Md.

COUNTY STATE

24. FUNERAL DIRECTOR  
NAME

Robt E Wilhelm

4308 Suitland

25a. DATE REC'D. BY REGISTRAR

AUG 4 1982

REGISTRAR'S SIGNATURE

Frank J. [Signature]

Funeral Home

ADDRESS

Rd., Suitland, Md.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH VITAL FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19096	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Viola Isabelle Marcellino</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>7 19 82</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 23, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2b. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>7 20 82</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indiana</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seamstress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>	
10. CITY OR TOWN OF DEATH <b>Edmonston</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4808 49th. Ave.</b>		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS <b>4802 49th. Ave.</b>		13c. CITY OR TOWN <b>Edmonston</b>		13d. COUNTY <b>P.G.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>361-05-5855</b>		17. INFORMANT <b>Cosa L. Hicks</b>		ADDRESS <b>4808 49th. Ave. Edmonston, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>1830</b> IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>advance ca of ovary</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Said A. Dace, M.D.</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER		DATE SIGNED <b>July 20, 1982</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Said A. Dace, M.D.</b>				ADDRESS <b>5632 Annapolis Road, Suite # 4 Bladensburg, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>7-22-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 22 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Nathan</b>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19097	
1. DECEASED NAME (TYPE OR PRINT) <b>PANOGRIGORIOS S. MAROULIS</b>						2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTI- MATED <input type="checkbox"/>		MONTH DAY YEAR		2b. HOUR	
3 SEX <b>Male</b>						4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Greece</b>						7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Cheverly, Md.</b>						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George's Gen. Hosp./Med. Ctr.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Restaurateur</b>	
13a. STATE <b>Maryland</b>						13b. CITY OR TOWN <b>Pr. George's Mitchellville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>18104 Queen Anne Bridge Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Spiros Maroulis</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maria Morfessis</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>						16b. SOCIAL SECURITY NO. <b>579-56-2260</b>		17. INFORMANT ADDRESS <b>John Maroulis 6712 Webster St., Hyattsville Maryland.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Multiple injured due to car accident.</b> <b>8199</b> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Abolghassem Hatf</b>				M.D. <b>Deputy</b>				DATE SIGNED <b>7/8/82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Abolghassem Hatf, M.D.</b>				ADDRESS <b>Prince George's Gen. Hospital Cheverly, Maryland 20785</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>7/12/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons Inc.</b> ADDRESS <b>5130 Wisc. Ave., N.W. Wash., D.C.</b>								25a. DATE REC'D BY REGISTRAR <b>JUL 12 1982</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					7 2 1 9 0 9 8				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
ANNIE R. MARSHALL					MONTH DAY YEAR 07-27-82				
3. SEX F					2b. HOUR 3:15AM				
4. RACE Black					6. AGE (IN YEARS LAST BIRTHDAY) 62				
5. DATE OF BIRTH MONTH DAY YEAR Oct 25 1919					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md					9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD				
7b. CITIZEN OF WHAT COUNTRY? U.S.A.					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic				
10. CITY OR TOWN OF DEATH CHEVERLY					12b. KIND OF BUSINESS OR INDUSTRY				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH A CITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSP.					13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13b. STATE Md					13c. STREET ADDRESS 2431 Kent Village bl				
13c. CITY OR TOWN Landover					15. MOTHER'S MAIDEN NAME Ella Jones				
14. FATHER'S NAME James Marshall					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				
16b. SOCIAL SECURITY NO. 577-56-3998					17. INFORMANT ADDRESS Sue Marshall 1539 MARLEN ST. N.W.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>manipulation</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic colon cancer</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>1539</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1539</u>									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from <u>summer 81</u> to <u>July 27 82</u> , that (1) <u>Dr. Hardab</u> saw the deceased alive on <u>July 28 82</u> , and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>we</u> (did) (did not) view the body after death.									
22b. SIGNATURE DEGREE									
22c. DATE SIGNED 7/27/82									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. HARDAB									
22e. ADDRESS Hyattsville, Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)									
23b. DATE 7-31-82									
23c. NAME OF CEMETERY OR CREMATORY Resurrection									
23d. LOCATION CITY OR TOWN COUNTY STATE Clinton Md									
24. FUNERAL DIRECTOR H. S. Washington & son 4925 Dunwoody Ave NE									
25a. DATE REC'D. BY REGISTRAR AUG 6 1982									
25b. REGISTRAR'S SIGNATURE John J. Canine									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					8 2 1 9 0 9 9 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELLEN E MAY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>07 21 82</b>			2b. HOUR P M <b>7:29 M</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 11, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY MD.</b>				
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Mt. Rainier</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John F. Lloyd</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosa B. Edwards</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>577-20-6980</b>		17. INFORMANT ADDRESS <b>3803 56th. Ave.</b> <b>Margaret E. Cichocki Hyattsville, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4140 IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>(b) Atherosclerotic Heart Disease</b> <b>(c) Small Bowel Obstruction</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>July 20, 19 82</b> , to <b>July 21, 19 82</b> , that (I) (we) lost saw the deceased alive on <b>July 21, 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign the body after death.										
22b. SIGNATURE <b>J. R. Miles, M.D.</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>July 22, 1982</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN R. MILES M.D.</b>					22e. ADDRESS <b>Pr. Geo. Gen. Hospital - Cheverly, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7-26-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Arlington Va.</b>			
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>					25. DATE REC'D BY REGISTRAR <b>JUL 26 1982</b>					

MEDICAL CERTIFICATION



Female	White	Sept. 11, 1904	77
Washington, D.C.	U.S.A.	x	
CHERRY	PRINCE & GEORGE'S HOSPITAL	Homeville	Own home
Virginia	U.S.	Mt. Rainier	x
John	F.	Lloyd	Ross
No	77-80-80R	Margaret E. Cichocki Hyattsville, Md.	3802 76th. Av. Richmond

*Handwritten notes:*  
 1. 100-100-100  
 2. 100-100-100  
 3. 100-100-100

x

July 21, 82	July 21, 82	July 21, 82	July 21, 82
x			

July 21, 1982

7-20-82 Arlington Natl. Cem. Arlington Va.

7-20-82 E. Gasch's sons E.H. & L.A. Hyattsville, Md.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19100	
1. FOR STATE REGISTRAR											
2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Muriel Eleanor McCampbell</b>										2a. DATE KNOWN OF DEATH ESTI. MATED <input type="checkbox"/> MONTH DAY YEAR 19 <b>7 20 82</b> 7b. HOUR M <b>10P</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 20, 1905 77</b>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>77</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 19 <b>7 21 82</b>		7d. HOUR M <b>9:10</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6001 43rd. Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6001 43rd. Street</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alonzo Turner</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maude Harding</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>577-30-0722</b>		17. INFORMANT ADDRESS <b>406 Richton Ct. Mrs. Ann Louise Moss Upper Marlboro, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: <b>4019</b> IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>Depression</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>Said A. Daee, M.D.</b>				DATE SIGNED <b>July 21, 1982</b>				MEDICAL EXAMINER <b>5632 Annapolis Road Suite # 4 Bladensburg, Maryland</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Said A. Daee, M.D.</b>				ADDRESS <b>Bladensburg, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>July 23, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Brentwood</b> COUNTY <b>P.G.</b> STATE <b>Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 23 1982</b>				REGISTRAR'S SIGNATURE <b>[Signature]</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 2 1 9 1 0 1		
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
GREGORY LAMONT MCCLUNG					JULY 14, 1982	6:40 p.m.
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	7. UNDER 1 YEAR MONTHS DAYS	
MALE	BLACK	JULY 14, 1982		YRS.	13 22	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	UNITED STATES			PRINCE GEORGE'S COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
ANDREWS AFB	MALCOLM GROW USAF MEDICAL CENTER		NONE			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MARYLAND		PRINCE GEORGES	ANDREWS	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	4611-4 LAUREL CT	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
JAMES EDWARD MCCLUNG, JR.		TERESA MARIE ROBINSON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS		
NO		NONE		JAMES E. MCCLUNG, JR. AAFB, MD 20331 4611-4 LAUREL CRT.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> 7419 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Congenital Myelocystocele</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe Congenital Myelocystocele</u> Approximate interval between onset and death						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 14</u> , 19 <u>82</u> , to <u>JULY 14</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>JULY 14</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Thomas Steinour</u>		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> HOUSE STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>14 July 82</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
THOMAS STEINOUR, CAPT, USAF, MC		MALCOLM GROW USAF MC, AAFB, MD 20331				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
burial/removal		7-23-82	FLORAL PARK		Indianapolis Indiana	
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
FRAZIER'S 389 RHODE ISLAND AVE. NW		JUL 30 1982		<u>Thomas Steinour</u>		



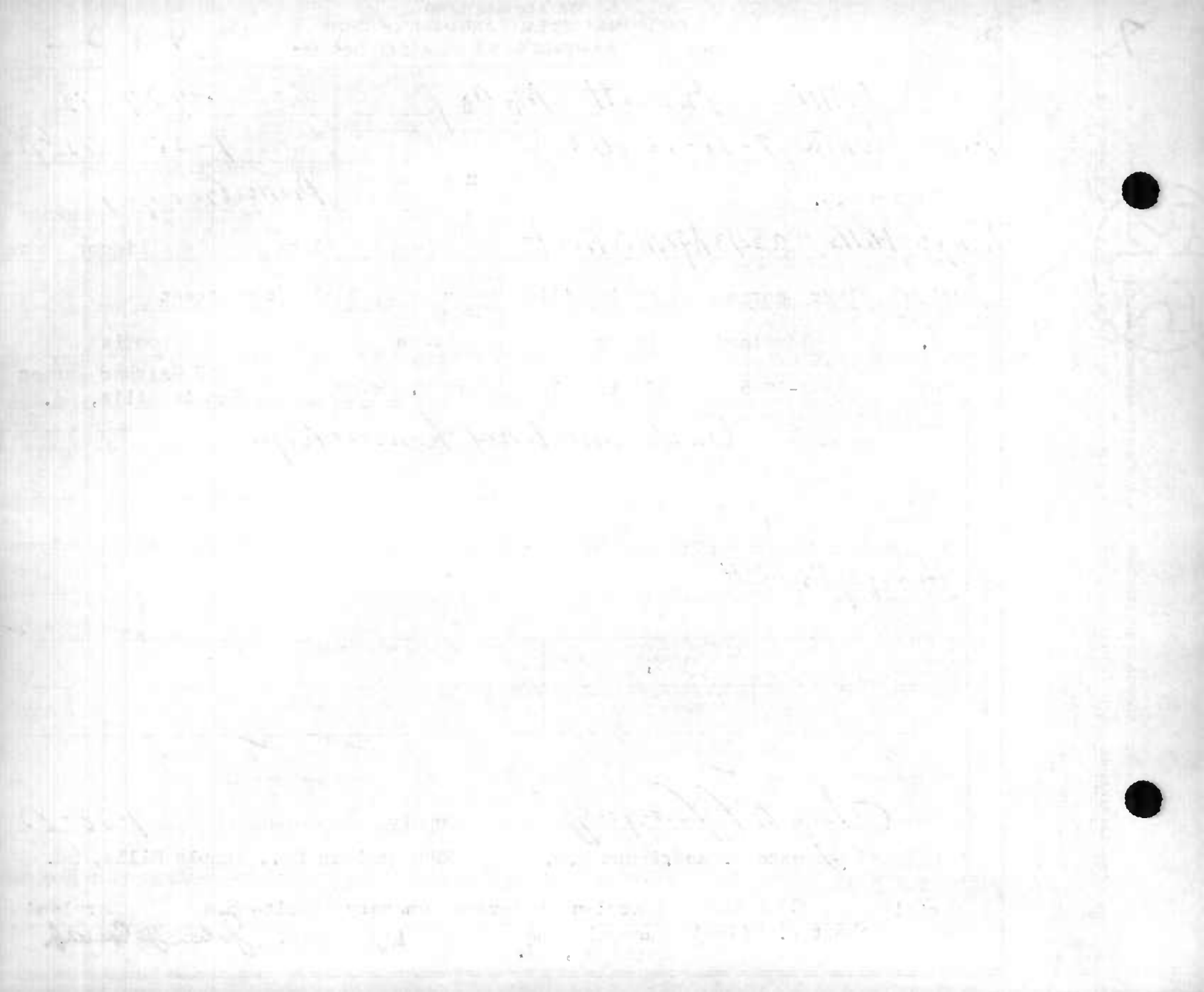
Handwritten notes and diagrams on lined paper. The text is mostly illegible due to fading and bleed-through. Faintly visible words include "NOTION", "BUT", and "MAY".

Handwritten notes in the right margin, possibly a list or sequence of items.



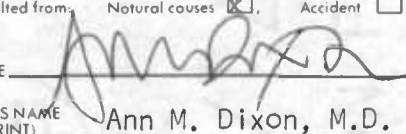

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19102	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Bennett McCoy										2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 7-27 1982	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7-18-18	6. AGE (IN YEARS) LAST BIRTHDAY 63 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD 7-28 1982		7d. HOUR M 6:30			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel		MD.			
10. CITY OR TOWN OF DEATH Temple Hills		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2243 Afton Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Liquor Store			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Pr George		13c. CITY OR TOWN Temple Hills		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2243 Afton Street			
14. FATHER'S NAME FIRST MIDDLE LAST H. Cleveland McCoy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Loomis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1943-1946		17. INFORMANT Gary W. McCoy		ADDRESS 2507 Gaither Street Temple Hills, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 5789 IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>History of H30H</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u>				TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER				DATE SIGNED 7-28-82			
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D.				ADDRESS 5009 Rayburn Ct., Temple Hills, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3 Aug 1982		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Maryland			
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm				Funeral Home Suitland, Md.				25a. DATE RECD. BY REGISTRAR AUG 9 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>	



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 19103

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN A. MC FARLAND</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>7 27 1982</b>			2b. HOUR <b>10:02</b>		
3. SEX <b>Male</b>	4. RACE <b>Cauc.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2 13 31</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>51</b>	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>7 27 19 82</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Michigan</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) <b>Southern Maryland Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self Employed</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Auto Parts</b>
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE <b>Md.</b>	13b. COUNTY <b>Pr. Geo.</b>	13c. CITY OR TOWN <b>Ft. Wash.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>8201 Bernard Dr.</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>James F. McFarland</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Vera Limendoll</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>		(IF YES, GIVE WAR OR DATES) <b>none</b>		16b. SOCIAL SECURITY NO. <b>577-38-1996</b>		17. INFORMANT ADDRESS <b>Hilma McFarland same as item 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 7-28-82		
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>			ADDRESS <b>111 Penn St., Balto., Md. 21201</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>7/29/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P. G. Co. Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 4 1982</b>		25b. REGISTRAR'S SIGNATURE 		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1204



BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. You may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 9 1 0 4	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>LEDWORTH D MCGINNIS</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>07 21 82</b>			2b. HOUR <b>8:15A.M.</b>		
3. SEX <b>Male</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 16 22</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>60</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.					
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Draft Bear Tch.</b>			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Temple Hills</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5103 Abbott Dr.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Glenn McGinnis</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ona Crotty</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>yes WWII</b>						16b. SOCIAL SECURITY NO. <b>233-30-8645</b>		17. INFORMANT ADDRESS <b>Kathrine McGinnis same as item 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>BILATERAL CARCINOMA - LUNGS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 DAYS</b> <b>2 MONTHS</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE 1</b> , 19 <b>80</b> , to <b>JULY 21</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>JULY 20</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Bruno Kolega</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>7/21/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BRUNO KOLEGA - MD</b>						22e. ADDRESS <b>4400 STAMP RD. TEMPLE HILLS - MD 20748</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>7/22/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P.G. Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 23 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>			

MEDICAL CERTIFICATION

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U.S. Sales 6180 Oxon Hill Rd. Oxon Hill, Md.

Generation 7/22/82 Cedar Hill Observatory Butland T.O. 16.

Yes Will 233-30-0012 Katharine McGinnis name as item 13

Glenn McGinnis  
Dns  
Groty  
Mr. Geo. Temple Hills X 3103 Abbott Dr.  
Md.

West Virginia  
USA  
Male  
Cauc.  
16 22 60  
Netted Inlt Beer Tob.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 1 9 1 0 5  
REG. NO.1. FOR  
STATE  
REGISTRAR

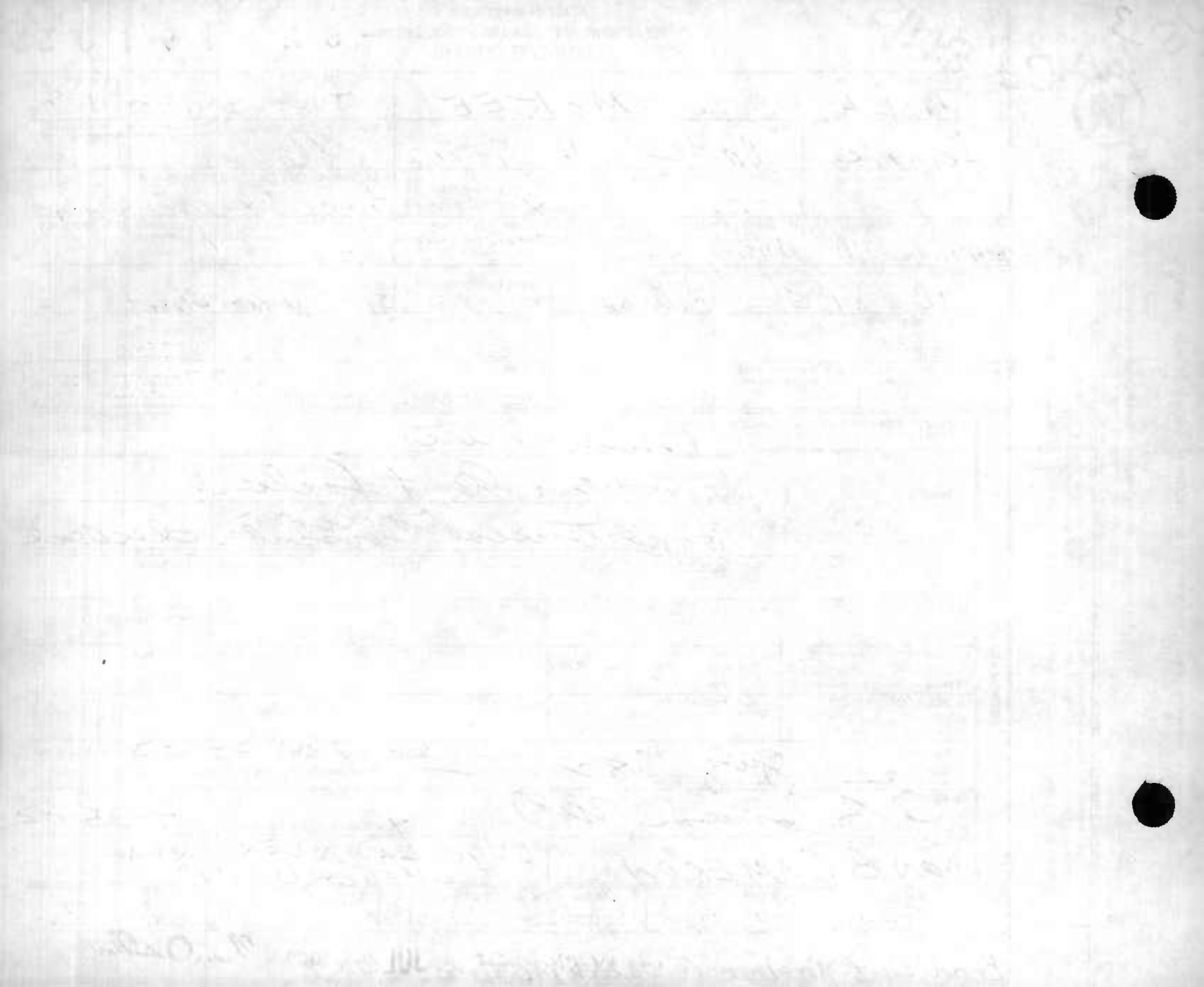
1. DECEASED NAME (TYPE OR PRINT) VIOLE A. MCKEE		2a. DATE OF DEATH MONTH DAY YEAR JULY 24, 1982		2b. HOUR 11:30 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 19 96	
6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		8. CITIZEN OF WHAT COUNTRY? U.S.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		10. CITY OR TOWN OF DEATH Hagerstown, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Nursing Home Manor Care	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY		13. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County, MD	
14. FATHER'S NAME FIRST MIDDLE LAST Delmar Oakman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delamiry Kline		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
17. SOCIAL SECURITY NO. 174-20-9886		18. INFORMANT Herbert N. Barnhardt		19. ADDRESS 5447 Varnum Street Bladensburg, MD.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4029 DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive cardiac vascular disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (i.e.)		

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>July 19 82</u> and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>testified</u> (I did not) <u>testify</u> the body after death.		22b. SIGNATURE <u>Don B. Cameron MD</u>		22c. DATE SIGNED 7-25-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DON B. CAMERON		22e. ADDRESS 6490 LANDOVER ROAD CHELSEA, MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/26/82		23c. NAME OF CEMETERY OR CREMATORY Jerusalem Christian		23d. LOCATION CITY OR TOWN COUNTY STATE Fulton PA.	
24. FUNERAL DIRECTOR NAME Bradley L. Kneibrenner		ADDRESS 141 W. Main St Hagerstown MD 21750		25a. DATE REC'D. BY REGISTRAR JUL 28 1982		25b. REGISTRAR'S SIGNATURE <u>Robert J. [Signature]</u>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19106	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN T. MC VEARRY, Sr.										2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7 27 19 82	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 2, 1908		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 73		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH Hyattsville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6014 43rd St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Optician		12b. KIND OF BUSINESS OR INDUSTRY Optical Co.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Prince Georges Hyattsville										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Michael McVearry										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Bromley	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW 11		17. INFORMANT ADDRESS Lela E. McVearry Same as #13 (Wife)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging 9530 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 7-27- 19 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Hanged self.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION CITY OR TOWN COUNTY STATE 6014 43rd St., Hyattsville, Prince George's, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Ann M. Dixon				TITLE (SPECIFY) Assistant M.D.				DATE SIGNED 7-28-82			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial				23b. DATE 7/30/82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR NAME Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland						25a. DATE REC'D. BY REGISTRAR JUL 30 1982		25b. REGISTRAR SIGNATURE [Signature]			

White  
 Oct. 2, 1908  
 Washington, D.C.  
 Optician  
 Optical Co.

John  
 Michael  
 McVerry  
 John E. McVerry  
 777 02 0002  
 6014 17th Avenue  
 Ramsey

7/30/08  
 Lincoln Cemetery  
 Burial  
 Francis Joseph  
 7/30/08

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (J))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 1 9 1 0 7																					
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR																			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELWYN (NMN) MERIWETHER</b>										MONTH DAY YEAR <b>7 9 82</b>		19 82 905 M																			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH (MONTH DAY YEAR) <b>July 18, 1900</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>81</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR																			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Texas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b>		10. CITY OR TOWN OF DEATH <b>Riverdale</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Leland Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Printer</b>		12b. INDUSTRY OF BUSINESS OR INDUSTRY <b>Government</b>																	
13a. STATE <b>Maryland</b>										13b. COUNTY <b>Prince Geo.</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5402 37th Avenue</b>															
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lewis Meriwether</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances Keen</b>																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>										16b. SOCIAL SECURITY NO. <b>460 05 7104</b>		17. INFORMANT ADDRESS <b>Virginia Meriwether Same as #13 (Wife)</b>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>ASVD</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION FIRST STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																															
ACTUAL SIGNATURE <b>SAID A. DARR MD</b>										TITLE (SPECIFY) <b>Deputy</b>										DATE SIGNED <b>7-10-82</b>											
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>										23b. DATE <b>7/13/82</b>										23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>										23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood, P.G. Maryland</b>	
24. FUNERAL DIRECTOR'S NAME <b>Francis Gasch's Sons Funeral Home, P.A.</b>										25a. DATE REC'D. BY REGISTRAR <b>JUL 13 1982</b>										25b. REGISTRAR'S SIGNATURE											
24. ADDRESS <b>Hyattsville, Maryland</b>																															

MEDICAL CERTIFICATION

BP

RECEIVED BY THE DIRECTOR  
JULY 1 1984

(10)

Prince George

Printer

2005 7th Avenue

Prince

Northwest

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Virginia Northwest 2000 7th Avenue

1000 05 1984

1000

JUL 1 1984

1000 05 1984

1000 05 1984

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 2 1 9 1 0 8	
1- FOR STATE REGISTRAR		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARTHA MAE MERRILL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 18, 1982</b>		2b. HOUR <b>10:42am</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JAN 22, 1921</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>61</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>IOWA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>ANDREWS AFB</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MALCOLM GROW USAF MEDICAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>PRINCE GEORGE'S</b>	13c. CITY OR TOWN <b>CAMP SPRINGS</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN CHARLES WALTER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BERTHA MAE HART</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT <b>CHARLES T. MERRILL, 5509 WINDSOR DR.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac and respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4275</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE 14</b> , 19 <b>82</b> , to <b>JULY 18</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Hilary Ellwood MD</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c. DATE SIGNED <b>18 July 82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HILARY ELLWOOD, CAPT, USAF, MC</b>		22e. ADDRESS <b>MALCOLM GROW USAF MC, AAFB, MD 20331</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JULY 21, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>	
23d. LOCATION CITY OR TOWN <b>ARLINGTON, VIRGINIA</b>		23e. LOCATION COUNTY STATE <b>VIRGINIA</b>			
24. FUNERAL DIRECTOR Lee Funeral Home, Inc. NAME <b>6633 Old Alexander Ferry Road, Clinton, Maryland 20735</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>35 JUL 21 1982 Frances Jean Nathan</b>			

BP  
DHMH - 16 50M 1/81  
(VRA 15, 4)





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1951

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 9 1 0 9	
1- FOR STATE REGISTRAR			REG. NO.								
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
Lillie A. Mockabee						July 30, 1982			6:40 am		
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN	
Female		White		10 3 1895		86 YRS					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Wash. D.C.		USA				Prince George's County MD					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Laurel, Md.		Greater Laurel Beltsville Hospital				Retired		Fed. Gov't.			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS		
MD.			P.G.		Clinton				11405 Accolade Terr.		
14 FATHER'S NAME FIRST MIDDLE LAST					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Thomas F. Dean					Margaret E. Quade						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS						
No			577-50- 3881		Raymond E. Heil (as above)						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> 4860 DUE TO, OR AS A CONSEQUENCE OF (b) <u>PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>POPLITEAL ARTERY EMBOLIZATION</u>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (a) this hospital attended the deceased from <u>7/19</u> 19 <u>82</u> , to <u>7/30</u> 19 <u>82</u> , that (b) (we) last saw the deceased alive on <u>7/30</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (b) (we) did (did not) view the body after death.											
22a SIGNATURE <u>Gregory A. Compton</u>					DEGREE		22b DATE SIGNED <u>7/30/82</u>				
22c ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Gregory A. Compton</u>					22e ADDRESS <u>14201 Lanna Park DR #109 MD</u>						
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE				
Burial			Aug. 2, 1982		Mt. Olivet		Wash., D.C. <u>Prince George's</u>				
24 FUNERAL DIRECTOR NAME ADDRESS					25a DATE REC'D. BY REGISTRAR <u>AUG 4 1982</u> 25b REGISTRAR'S SIGNATURE <u>[Signature]</u>						
Kalas F.H. 6160 Oxon Hill Rd. Oxon hill, Md.											

Dallas F.H. 6160 Oxon Hill Rd. Oxon Hill, Md.  
 Aug. 7, 1982 Mt. Olivet  
 Wash., D.C.

Robert A. Johnson  
 12/18/82  
 1/20/83

Political Activity Registration

571-20-3881  
 Raymond E. Hill (as above)

No Thomas E. Dean Margaret E. Made  
 MD. P.O. Clinton x 1105 Acclade Terr.  
 Laurel, Md. Wash. D.C.

Female white 10 3 1982 86  
 Retired Fed. Gov't.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

FOR 1. STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 9 1 1 0 CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
THOMAS E MOLYNEUX						July 6, 1982				4:44 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE		White		MONTH DAY YEAR Sept 2 1925		56 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.					
Illinois		USA									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Clinton		Southern Maryland Hospital Center				ACCT MGR		Swift Co			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		234 West Pine Street			
DeL		Sussex		Georgetown							
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Edmond J. Molyneux				Marie Baird							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR/DATE)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Yes WW II				345-16-2703		Rosemary Molyneux		Georgetown, De			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1729 IMMEDIATE CAUSE (a) CARDIO PULMONARY FAILURE, HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF (b) ADVANCED MALIGNANT METASTATIC DUE TO, OR AS A CONSEQUENCE OF (c) MELANOMA. Approximate interval between onset and death: 1 1/2 hrs.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: COAGULOPATHY + POSS. Renal failure											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK AT HOME <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/6 - 7/2, 1982, to 7/6, 1982, that (I) (we) lost saw the deceased alive on 7/6, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE G.S. Crover MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7/7/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G.S. CROVER				22e. ADDRESS 7501 SURFATTS RD #104							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL				7-10-82		UNION CEMETERY		Georgetown Sussex De.			
24. FUNERAL DIRECTOR NAME ADDRESS William H. ... Georgetown De.						25. DATE RECEIVED BY REGISTRAR JUL 14 1982		25b. REGISTRAR'S SIGNATURE Francis Jan. Nathan			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DEATH IS TO BE BURIED, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DEATH IS TO BE BURIED, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DEATH IS TO BE BURIED, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19111	
1. DECEASED NAME (TYPE OR PRINT) <b>David P Montague Jr</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>7 27 1982</b>	
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 16 19 63</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD <b>7 27 1982</b>		2b. HOUR <b>4:45 PM</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE MD.</b>				
10. CITY OR TOWN OF DEATH <b>LAUREL</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER LAUREL - BELTSVILLE HOSP. - OWNER -</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>OPERATOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>T.V. REPAIR</b>		
10a. STATE <b>MD</b>		10b. COUNTY <b>PRINCE GEORGE</b>		10c. CITY OR TOWN <b>BELTSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13a. STREET ADDRESS <b>4424 ROMAN ST</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>DAVID PHILIP MONTAGUE</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA R. SINKIND</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>579-09-8371</b>		
17. INFORMANT <b>KATHERINE MONTAGUE AS ABOVE</b>			17. ADDRESS <b>SAME</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4408 IMMEDIATE CAUSE (a) Cardiac arrest</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: <b>ASVD</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASVD</b> DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>SAID A. DAE MD</b>				M.D. <b>Deputy</b>				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) <b>SAID A. DAE</b>				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (RECORD) <b>CREMATION</b>				23b. DATE <b>JULY 29 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Md</b>			
24. FUNERAL DIRECTOR NAME <b>DONALDSON FUNERAL HOME</b>				ADDRESS <b>LAUREL MD</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 5 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 2 1 9 1 1 2				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR				
FRED I. MOORE					7/17/82				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
M		B		9 30 55		26 YRS.		8:15 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. SEPARATED - MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		US				PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
LAUREL		GREATER LAUREL BELTSVILLE HOSP				INT. DESIGN		DESIGN	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS		
13a. STATE MD 13b. COUNTY P.G. 13c. CITY OR TOWN LAUREL					YES <input type="checkbox"/> NO <input type="checkbox"/>		196 ERTTER DR., LAUREL MD		
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
MOSE MOORE					MABEL POWELL				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
YES					1915-1979		212-64-9255 Vanessst A. Moore 3393 Suderville St. Laurel, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphoma									
2028 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
7/6/82			GASTRIC ULCER			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
			P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
Richard Chasen					M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			7/17/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
RICHARD CHASEN									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Cremation			7-22-82		Lee's Crematorium		Washington, D.C.		
24. FUNERAL DIRECTOR NAME					25a. DATE RECD. BY REGISTRAR		REGISTRAR'S SIGNATURE		
George R. Snowden					246 N. Wash. Rockville, MD.		JUL 22 1982 Frances Jan Thorton		

22

Handwritten notes and text, mostly illegible due to blurriness and bleed-through. Some visible words include "MAY", "JULY", and "A".

Handwritten notes and text, mostly illegible due to blurriness and bleed-through. Some visible words include "MAY", "JULY", and "A".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	1	9	1	1	3
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret Grace A. Mullen										2a. DATE OF DEATH MONTH DAY YEAR July 29, 1982				2b. HOUR P. 12:50M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 15, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.										
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Home, Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse		12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE District of Columbia				13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5425 Connecticut Ave., N.W.						
14. FATHER'S NAME FIRST MIDDLE LAST John A. Mullen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bridget E. Tierney				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No								
16b. SOCIAL SECURITY NO. 577-60-4747				17. INFORMANT Neice Patricia H. Raleigh /Fairfax Virginia				ADDRESS 3530 Queen Anne								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5070 DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia (Aspiration) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Brain Syndrome @ Hypertension																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from Dec 30, 1980, to July 29, 1982, that (I) (we) lost saw the deceased alive on 6/1/82, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE [Signature]				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/29/82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE July 30, 1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Springs, Maryland								
24. FUNERAL DIRECTOR NAME Robert A. DeSal				ADDRESS 2222 Wisc. Ave. Washington D.C.				25a. DATE REC'D. BY REGISTRAR AUG 2 1982								
								25b. REGISTRAR'S SIGNATURE James Santhron								

BP

1001

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

19114

1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>Melvin P.</b>		MIDDLE <b>P.</b>		LAST <b>Nicholson</b>		2b. DATE KNOWN OF DEATH ESTIMATED		MONTH <b>7</b>		DAY <b>27</b>		YEAR <b>1982</b>		2d. HOUR <b>12:29</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOV. 13, 1916</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>65</b> YRS		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD <b>7 27 1982</b>		2d. HOUR <b>12:29</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S</b>				MD.			
10. CITY OR TOWN OF DEATH <b>BOWIE</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bowie Health Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEAR) <b>PRODUCE FARMER</b>				12b. KIND OF BUSINESS <b>BUSINESS</b>							
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>PR. GEO'S</b>				13c. CITY OR TOWN <b>UPPER MARLBORO</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS <b>16702 SWANSON ROAD</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>REVERDY -- NICHOLSON</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IRENE -- BUTLER</b>				16. SOCIAL SECURITY NO.				17. INFORMANT <b>MILDRED NICHOLSON-UPPER MARLBORO, MARYLAND 20772</b>				ADDRESS <b>16702 SWANSON RD.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO.</b>				16b. (IF YES, GIVE WAR OR DATES) <b>----</b>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4408 IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>ASVD</b> DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <b>SAID A. DAEE</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER <b>5632 ANNAPOLIS ROAD</b>				DATE SIGNED <b>7-27-82</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>SAID A. DAEE, M.D.</b>				ADDRESS <b>BLADENSBURG, MARYLAND</b>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>7/30/82</b>				23c. NAME OF CEMETERY OR CREMATORY <b>TRINITY CEMETERY</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>UPPER MARLBORO (Pr. Geo's) MD</b>							
24. FUNERAL DIRECTOR <b>RICHARD A. COLEMAN</b>				ADDRESS <b>UPPER MARLBORO, MARYLAND 20772</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 05 1982</b>				25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #M 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 4, AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

NOV. 13, 1915

U. S. A.

MAINE

BOONE

MAINE - BR. 1915

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U. S. A.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST DANIEL		MIDDLE G.		LAST O'Connell		2a. DATE OF DEATH		KNOWN ESTI- MATED		MONTH 7		DAY 9		YEAR 1982		7b. HOUR 9P											
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Apr. 4, 1904		6. AGE (IN YEARS) (LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH 7		DAY 9		YEAR 1982		2d. HOUR 9P											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Pr. Geo. MD.																							
10. CITY OR TOWN OF DEATH Mt. Rainier		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) 3628-Rhode Is. Ave.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Catholic Priest						12b. KIND OF BUSINESS OR INDUSTRY -															
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																													
13a. STATE Md.				13b. COUNTY Pr. Geo.				13c. CITY OR TOWN Mt. Rainier				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 3628-Rhode Is. Ave.													
14. FATHER'S NAME FIRST MIDDLE LAST Daniel G. O'Connell										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Hart																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes										16b. SOCIAL SECURITY NO. 300-50-5646										17. INFORMANT ADDRESS Fr. Robert H. Wharton- above address-									

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

4100  
Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

IMMEDIATE CAUSE (a) Cardiac arrest  
DUE TO, OR AS A CONSEQUENCE OF  
(b) ASVD MI had Pacemaker  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

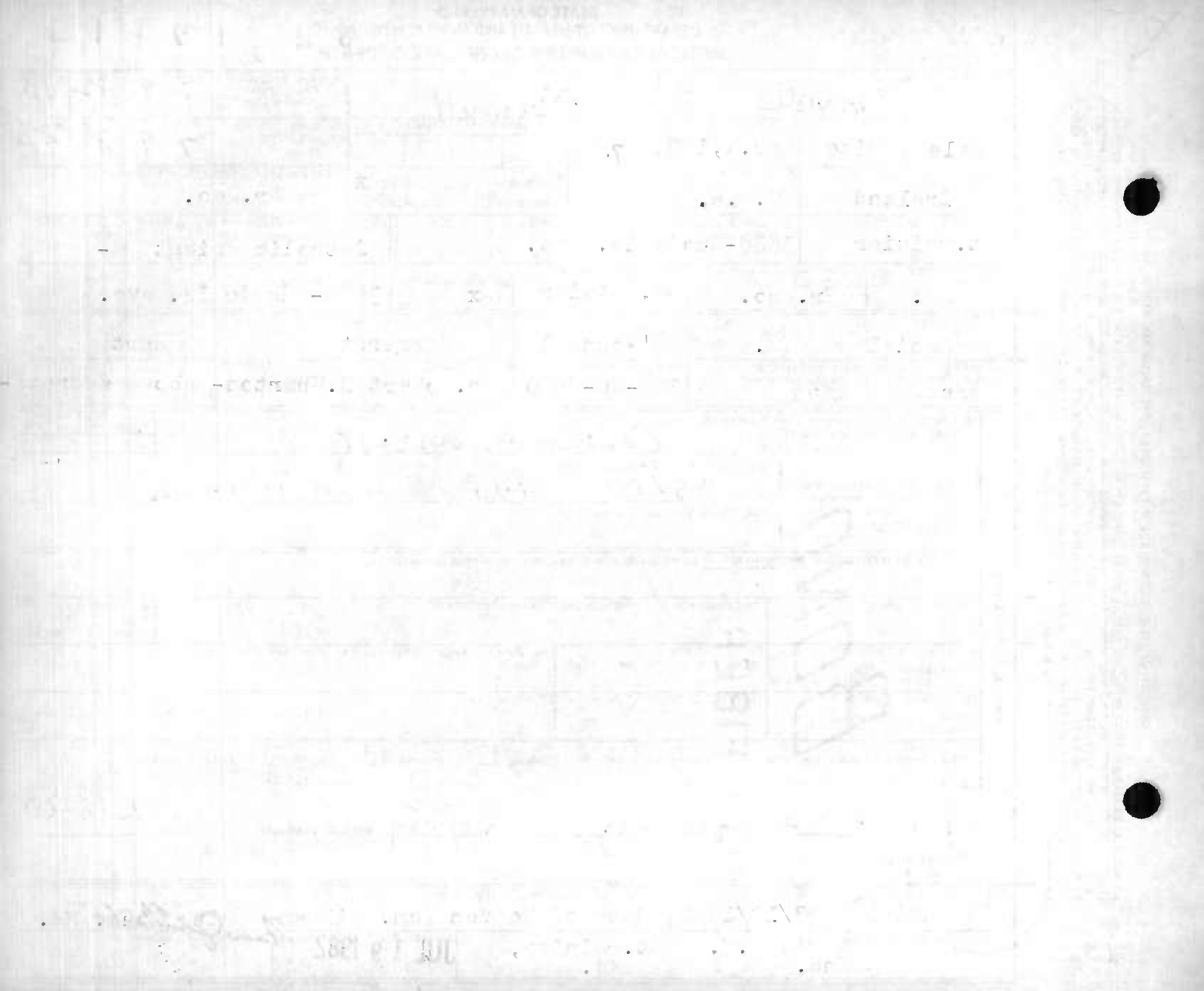
APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>SAID A DARR MD</u>		TITLE (SPECIFY) <u>Deputy</u>		DATE SIGNED <u>7-10-82</u>	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/13/1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN Silver Spring Md.		COUNTY Montgomery		STATE Md.	
24. FUNERAL DIRECTOR NAME Valley's F.H. Inc.		ADDRESS Mt. Rainier, Md.		DATE REC'D BY REGISTRAR JUL 19 1982		MEDICAL EXAMINER'S SIGNATURE <u>[Signature]</u>					





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. (PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES.)  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19116	
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE C. LAST OLIFF										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7 4 19 82	
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR 12 27 1944		6. AGE (IN YEARS) LAST BIRTHDAY 32 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 7 4 19 82		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. DC.		7b. CITIZEN OF WHAT COUNTRY? USA.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.				
10. CITY OR TOWN OF DEATH New Carrollton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7613 Fountain Blvd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECT.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD.		13b. COUNTY PG.		13c. CITY OR TOWN New Carrollton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7613 Fountain Blvd			
14. FATHER'S NAME FIRST MIDDLE LAST ARTHUR Anthony Kicsar					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dolores Bernadette Shineck						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Arthur Kicsar Lusby MD 20657					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4300 Subarachnoid hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Ann M. Dixon, M.D.		TITLE (SPECIFY) Assistant		MEDICAL EXAMINER				DATE SIGNED 7-5-82			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (TYPE IF)		23b. DATE 8 July 82		23c. NAME OF CEMETERY OR CREMATORY Our Lady of the Sea				23d. LOCATION CITY OR TOWN COUNTY STATE Solomons Island Maryland			
24. FUNERAL DIRECTOR NAME Louis L. Grant		ADDRESS London FH 908 ANNAPOLIS MD		25a. DATE OF RECORD JUL 12 1982				25b. SIGNATURE			

ORIGINAL

RECEIVED



Smith

Item 11 per phone 8/4/82 dad

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

JOSEPH

E.

O'NEILL

20. DATE KNOWN  
OF DEATH ESTI-  
MATED

MONTH

DAY

YEAR

20. HOUR

7

23

82

10A

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

1 12 18

6. AGE (IN YEARS)

64

IF UNDER 1 YR.

MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS.

7c. DATE

Pronounced  
Dead

MONTH

DAY

YEAR

2d HOUR

7

23

82

10A

7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

England

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince Georges Co. MD.

10. CITY OR TOWN OF DEATH

Laurel

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

Laurel Hospital

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

Administrator

12b. KIND OF BUSINESS  
OR INDUSTRY

Civil Service

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE 13b. CITY OR TOWN

England Ox Fordshire Middle Bolton

13c. INSIDE CITY LIMITS?

YES ☐ NO ☐

13d. STREET ADDRESS

23 Holliers Crescent

14. FATHER'S NAME

Matthew

MIDDLE

LAST

O'Neill

15. MOTHER'S MAIDEN NAME

Agnes Jane

MIDDLE

LAST

Watt

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

Yes WWII + Korea

16b. SOCIAL SECURITY NO.

050-03-8184

17. INFORMANT

Robt. O'Neill

ADDRESS

4491 Powder Mill Rd  
Beltsville, Md. 20705

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

1629 IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

respiratory arrest

(b) pneumonitis sepsis

DUE TO, OR AS A CONSEQUENCE OF

(c) Carcinoma of the lung

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ ORCONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an

Autopsy ☐Inspection ☐Inquiry ☐

and in my opinion

death resulted from: Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐ACTUAL  
SIGNATURE

SAID A. DARR MD

M.D.

Deputy

MEDICAL EXAMINER

DATE  
SIGNED

7-23-82

EXAMINER'S NAME  
(TYPE OR PRINT)

ADDRESS

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

July 27, 1982

23c. NAME OF CEMETERY OR CREMATORY

Evergreen Mem. Gdn

23d. LOCATION  
(CITY OR TOWN)

Finksburg

COUNTY

Carroll Md.

24. FUNERAL DIRECTOR  
NAME

H. J. Schardt

ADDRESS

Owings Mills Md.

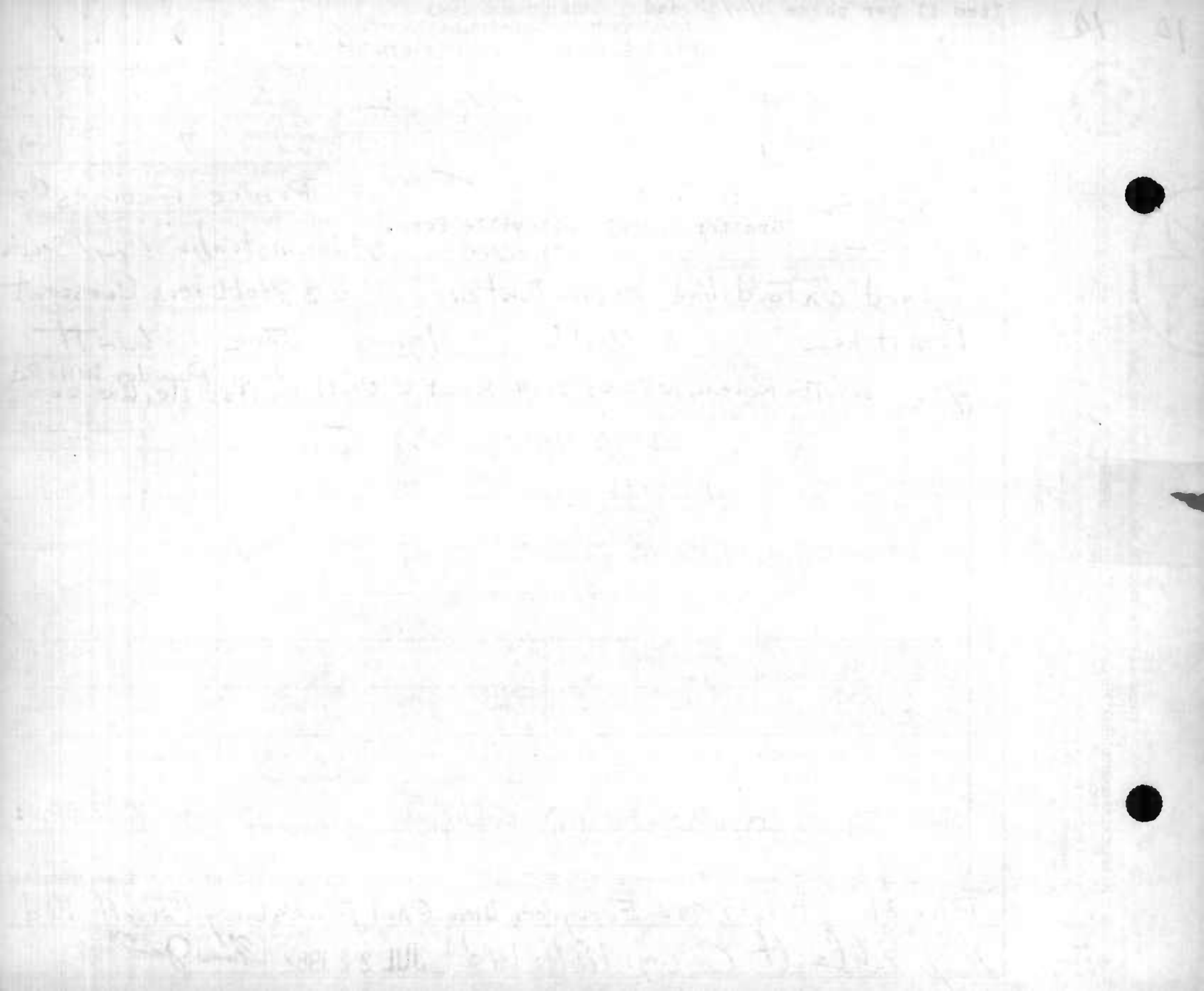
25a. DATE REC'D. BY REGISTRAR

JUL 28 1982

25b. REGISTRAR'S SIGNATURE

James J. Smith

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1 - FOR STATE REGISTRAR					8 2 1 9 1 1 8					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					
Ronald R Osbourn					7 22 82 10 14 AM					
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR		
MALE		WHITE		2 8 59		43 YRS		10 14 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
Michigan		USA				Prince Georges MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Forestville		Regency Nursing Home				self employed		Service Sta.		
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland					Anne Arundel		Edgewater		70 Tarragon Lane	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
Arthur R. Osbourn					Frances Dukarski					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
yes					362-38-4669		Mary E. Osbourn same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										
2396 IMMEDIATE CAUSE (a) malignant brain tumor.										
DUE TO, OR AS A CONSEQUENCE OF (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 6-2-82, 1982, to 7-22, 1982, that (I) (we) last saw the deceased alive on 7-22, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE					DEGREE			22c. DATE SIGNED		
William Kent Furst					MD			7-22-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
William Furst MD					9401 Indian Head Highway Ft. Washington, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY			
Burial			Jul 24 1982		George Washington		Adelphi, Md.			
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR?					
Beall Funeral Home					JUL 28 1982					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by item 35.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1- FOR STATE REGISTRAR					7- REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Edward OWENS</b>					7a. DATE OF DEATH MONTH DAY YEAR <b>July 31, 1982</b>			7b. HOUR <b>8:20p M</b>		
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 15, 1886</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's MD.</b>				
10. CITY OR TOWN OF DEATH <b>Lanham</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Doctors' Hospital of Pr. Geo. Co.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Upper Marlboro</b>		13c. CITY OR TOWN <b>Upper Marlboro</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Henrietta Jones</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>			16b. SOCIAL SECURITY NO. <b>217 36 7455</b>		17. INFORMANT ADDRESS <b>William Hall-son-in-law-506 S.E. Crain Highway, Upper Marlboro, Md</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left Cerebrovascular accident</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis of the Cardiovascular System</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Pneumonia</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1965</b> to <b>7/31</b> 19 <b>82</b> , that (I) <del>met</del> lost saw the deceased alive on <b>7/31</b> 19 <b>82</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death.										
22b. SIGNATURE <b>A. Clark Holmes, M.D.</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>8/1/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. Clark Holmes, M.D.</b>					22e. ADDRESS <b>14314 Old Marlboro Pike Upper Marlboro, Md. 20870</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug. 4, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Nebo Church Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Upper Marlboro Md</b>			
24. FUNERAL DIRECTOR NAME <b>John T. Stewart</b>					24b. RECORD BY REGISTRAR'S SIGNATURE <b>John T. Stewart</b>					
24a. FUNERAL HOME <b>Stewart Funeral Home 4001 Benning Rd., N.E.</b>										

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UNITED STATES GOVERNMENT  
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>MARY Theresa PAHL</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>7-27-82</b>			2b. HOUR <b>4:35 P.M.</b>					
3. SEX <b>female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 3 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.							
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Manor</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>9604 Singleton Drive</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edwin V. Turney</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary M. Orr</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>					16b. SOCIAL SECURITY NO. <b>579-20-3931</b>		17. INFORMANT ADDRESS <b>John F. Pahl Husband Same as 13</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CACHEXIA</b> <b>3400</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>MULTIPLE SCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4YRS</b> <b>4YRS</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>NONE</b>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <b>8/2/1980</b> , 19 <b>82</b> , to <b>7/27/82</b> , 19 <b>82</b> , that (1) (we) last saw the deceased alive on <b>7/1/82</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) (did not) view the body after death.													
22b. SIGNATURE <b>[Signature]</b>				DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/27/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. SCHISLER MD</b>				22e. ADDRESS <b>7500 GREENWAY CM DR GREENBELT MD</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>July 30, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville Montgomery Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG-4 1982</b>							
500 University Blvd., W. Silver Spring, Md.						25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

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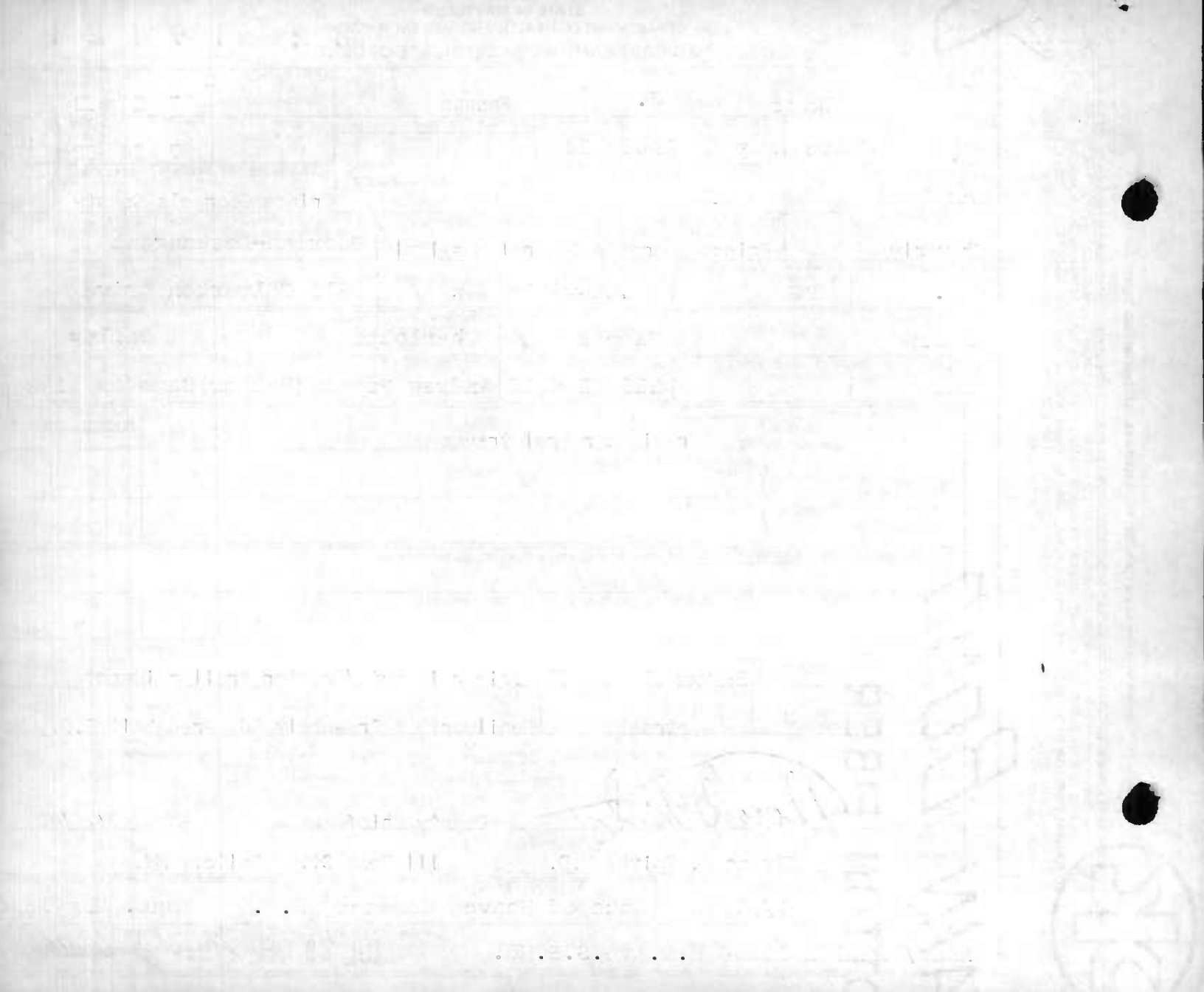
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19121	
1. DECEASED NAME (TYPE OR PRINT) <b>Thomas J. Pappas</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>7</b> DAY <b>24</b> YEAR <b>1982</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>May</b> DAY <b>28</b> YEAR <b>1962</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>20</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	2c. DATE PRONOUNCED DEAD MONTH <b>7</b> DAY <b>24</b> YEAR <b>1982</b>		2d. HOUR <b>9:05</b> A <b>M</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George's General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Doorman-Restaurant</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6813 Calverton Drive</b>			
14. FATHER'S NAME FIRST <b>Andrew</b> MIDDLE <b>Pappas</b> LAST <b>Pappas</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Charlotte</b> MIDDLE <b>Bailey</b> LAST <b>Bailey</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>None</b> (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. <b>215 82 6335</b>		17. INFORMANT ADDRESS <b>Andrew Pappas (Father) Same as #13E</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cranio cerebral trauma</b> 8120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3:30 AM 7 24 1982</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>driver in auto/tractor trailer impact</b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>		21f. LOCATION STREET <b>Kenilworth &amp; Greenbelt Rd.</b> CITY OR TOWN <b>Greenbelt</b> COUNTY <b>P.G.</b> STATE <b>Md.</b>							
22a. I certify that I took charge of the events described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Accident</b> <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Thomas D. Smith</b>				TITLE (SPECIFY) <b>M.D. Deputy Chief</b>				DATE SIGNED <b>7/25/82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn St. Balto., Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/27/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery S.S.</b>				23d. LOCATION CITY OR TOWN <b>Mont.</b> COUNTY <b>Maryland</b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi</b> ADDRESS <b>11800 N.H.Ave.S.S.Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 29 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Thomas D. Smith</b>					

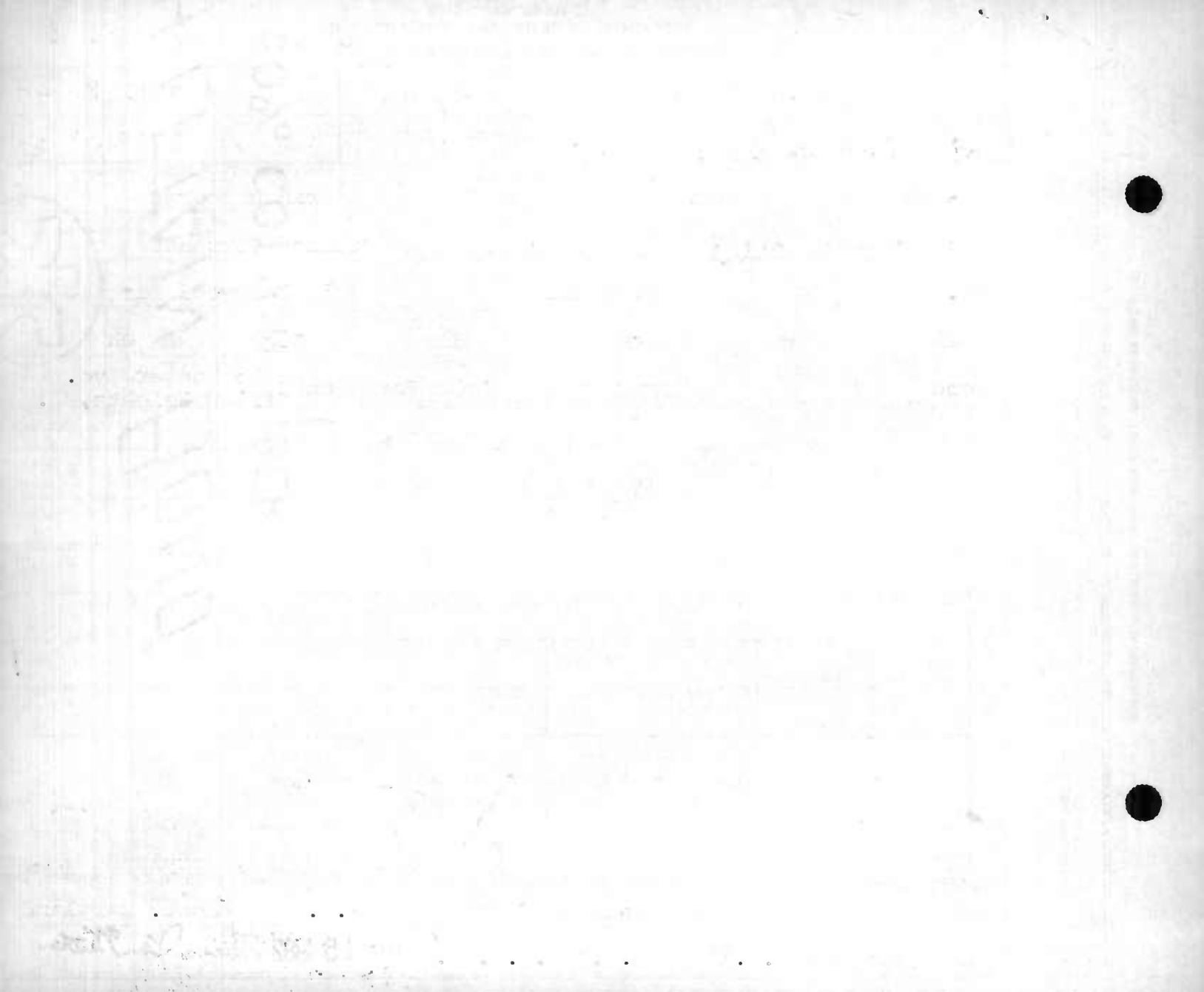


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19122	
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BONG Moses S. PARK										2b. HOUR 4A	
2. DATE OF DEATH MONTH DAY YEAR 7 10 82										2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 10 82	
3. SEX M										2d. HOUR 501A	
4. RACE ORIENTAL										2e. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
5. DATE OF BIRTH MONTH DAY YEAR Sep 4 05 77										2f. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
6. AGE (IN YEARS LAST BIRTHDAY) 7 YRS.										2g. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Korea										2h. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
7b. CITIZEN OF WHAT COUNTRY? Korean										2i. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
8. CITY OR TOWN OF DEATH Riverdale										2j. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
9. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 6215 Fernwood Terrace										2k. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
10. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md. PG Riverdale										2l. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
11. INSIDE CITY LIMITS? YES X NO										2m. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
12. STREET ADDRESS 6215 Fernwood Terrace										2n. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
13. FATHER'S NAME FIRST MIDDLE LAST Jab Paek Park										2o. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
14. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Il Boon Oh										2p. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) None										2q. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
16. SOCIAL SECURITY NO. 579-84-7629										2r. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
17. INFORMANT Duke Park (Son)										2s. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										2t. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
PART I DEATH WAS CAUSED BY: 4408 IMMEDIATE CAUSE (a) Cardiac arrest										2u. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
DUE TO, OR AS A CONSEQUENCE OF (b) ASVD										2v. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
DUE TO, OR AS A CONSEQUENCE OF (c)										2w. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										2x. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
19a. DATE OF OPERATION										2y. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										2z. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
20. AUTOPSY? YES NO										2aa. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH										2ab. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										2ac. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)										2ad. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK										2ae. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										2af. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE										2ag. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner										2ah. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
22b. ACTUAL SIGNATURE SAID A. DAEE MD M. Deputy										2ai. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
22c. EXAMINER'S NAME (TYPE OR PRINT) Said Daee										2aj. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
22d. ADDRESS Mitchellville, Maryland										2ak. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										2al. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
23b. DATE 7/12/82										2am. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
23c. NAME OF CEMETERY OR CREMATORY Gate Of Heaven										2an. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
23d. LOCATION CITY OR TOWN S.S. Mont. Maryland										2ao. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.										2ap. BALTIMORE CITY OR COUNTY OF DEATH Prince George	
25a. DATE REC'D BY REGISTRAR JUL 15 1982										25b. REGISTRAR'S SIGNATURE	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return to hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Please return to hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 9 1 2 3 REG. NO.			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST SYLVIA PERKINS		2a. DATE OF DEATH MONTH DAY YEAR 07-01-82				2b. HOUR 12:45A M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR October 1, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.							
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8903 Glenarden Parkway					
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Colbert				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irene Handy									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES AND OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-42-5644		17. INFORMANT Lionel G. Perkins				ADDRESS 8903 Glenarden Parkway Lanham, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Cardiorespiratory Arrest</u> 4254 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe Hypertension</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour years years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Diabetic mellitus</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>January 19 82</u> to <u>July 1 19 82</u> , that (I) (we) last saw the deceased alive on <u>5/27 19 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE <u>David M. Goldman</u>				DEGREE M.D.				22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID M. GOLDMAN M.D.				22e. ADDRESS 6525 BELCREST RD. HYATTSVILLE.MD. 20782									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/7/82		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park				23d. LOCATION CITY OR TOWN COUNTY Lanover Prince George's MD					
24. FUNERAL DIRECTOR NAME Rollins Funeral Home, Inc. 4339 Hunt Pl. N.E., Washington, D.C.				25a. DATE RECD. BY REG. OFF. JUL 7 - 1982				25b. REGISTRAR'S SIGNATURE <u>Charles J. W. Nathan</u>					



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 2 1 9 1 2 4

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Doris L. Phillips			2a. DATE OF DEATH MONTH DAY YEAR 7-9-82			2b. HOUR 1:50 PM			
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 16 1917		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Pr. Geo. MD.			
10 CITY OR TOWN OF DEATH Largo		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Major Care Nursing Home		12a. USUAL OCCUPATION (REQUIRE FOR MOST OF WORKING LIFE) Office Mgr.-		12b. KIND OF BUSINESS OR Occupation Lideng Co.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Seabrook		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9515 -Underwood St.	
14 FATHER'S NAME FIRST MIDDLE LAST William R. Kibler					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louisa May Fritts				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17 INFORMANT ADDRESS Clyde Phillips (above address) (Husband)				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 1629 Conditions, if any, which gave rise to immediate cause, (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Carcinoma to lungs</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/2</u> , 19 <u>82</u> to <u>7/9</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>7/8</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not witness the body after death, so state.)									
22b. SIGNATURE <u>Barry Rosenberg MD</u> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/9/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BARRY ROSENBERG, MD</u>						22e. ADDRESS <u>6501 Landover Rd Chevy Chase, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>7/12/1982</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Brentwood Pr. Geo. Md.</u>		
24 FUNERAL DIRECTOR NAME <u>Nalley's F.H. Inc. Mt. Rainier, Md.</u>						25a. DATE REC'D. BY REGISTRAR <u>JUL 15 1982</u>		25b. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

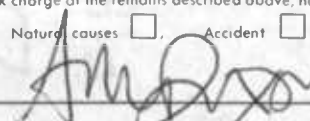

BP \_\_\_\_\_



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19125	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>EARNIE PHILLIPS</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 6 24 19 82	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Apr. 5, 1943</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>39</b> RS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7b. HOUR <b>7:50</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Texas</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County</b> MD.	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>water - Governor Bridge Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>District</b>		13b. COUNTY <b>of Columbia</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>905 6th Street, S.W.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Wells</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Beatrice Hines</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>459-68-7613</b>		17. INFORMANT ADDRESS <b>Mrs. Beatrice Wells-mother-6612 Forestville, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>9660</b> IMMEDIATE CAUSE (a) <b>Multiple stab wounds</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. 6-24- 19 82</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject stabbed.</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>apt.</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>905 6th St. SW Apt. 210 Wash., D.C.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>M.D. Assistant</b>				DATE SIGNED <b>6-27-82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>				ADDRESS <b>111 Penn St., Balto., Md. 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>July 8, 1982</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematorium</b>			
24. FUNERAL DIRECTOR NAME <b>Stewart Funeral Home</b>				ADDRESS <b>4001 Benning Road,</b>				25a. DATE RECEIVED BY REGISTRAR <b>July 12 1982</b>			
								25b. DATE RECEIVED BY REGISTRAR SIGNATURE 			

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

Serial 1122

DATE: 10-1-54

TO: DIRECTOR

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8 2 1 9 1 2 6							
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST MATTIE B. PITTS				2a. DATE OF DEATH MONTH DAY YEAR 07-23-82		2b. HOUR 10:53AM	
3 SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR May 2, 1898		6 AGE (IN YEARS LAST BIRTHDAY) 84		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12916 7th Street	
14 FATHER'S NAME FIRST MIDDLE LAST Bill Moses				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 577 12 7847A		17. INFORMANT ADDRESS 7A-Samuel Pitts, Jr.-son-12916 7th St. Bowie, Maryland					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u> 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetic mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Heart Failure</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 19, 1982</u> to <u>July 23, 1982</u> , that (I) (we) lost saw the deceased alive on <u>7/23, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Maig H. Ko</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>7/25/82</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MEIKEN H. KO</u>		22e. ADDRESS <u>666 H. M.D.</u>							
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE <u>July 29, 1982</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Memorial</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Park-Landover, Md.</u>			
24. FUNERAL DIRECTOR NAME <u>Stewart Funeral</u>		Home-4001 Benning Rd.,		25a. DATE REC'D. BY REGISTRAR <u>JUL 30 1982</u>		REGISTRAR'S SIGNATURE <u>James J. Smith</u>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, HEADS OF THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19127	
1. DECEASED NAME (TYPE OR PRINT) <b>Esther Naomi POSEY</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>7-28 1982</b>	
3. SEX <b>female</b>		4. RACE <b>black</b>		5. DATE OF BIRTH (LAST BIRTHDAY) <b>10-15-26</b> YEAR <b>55</b> YRS.		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>55</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		2c. DATE PRONOUNCED DEAD <b>7-28 1982</b> MONTH DAY YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b>	
10. CITY OR TOWN OF DEATH <b>Seat Pleasant</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>6420 Seat Pleasant Drive</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>	
13a. STATE <b>MD</b>				13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Seat Pleasant</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6420 Seat Pleasant Dr.</b>	
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Samuel C Adams</b>						15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Sophie Brandon</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>244-42-6499</b>		17. INFORMANT ADDRESS <b>Calvin Posey Same as 13 E</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetic arteriosclerosis, cerebral vascular disease</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Coronary atherosclerosis, carcinoma</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>				TITLE (SPECIFY) <b>M.D. Deputy</b>				DATE SIGNED <b>7-28-82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez M.D.</b>				ADDRESS <b>5009 Rayburn Ct., Temple Hills, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8-2-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove Cem</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Zebulga, N.C.</b>	
24. FUNERAL DIRECTOR NAME <b>H. S. Washington</b>				ADDRESS <b>4025 Benning Ave NE</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 6 1982</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an examiner must be notified and an

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					7 2 1 9 1 2 8				
I. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR				
Beatrice E PRICE					July 20, 1982				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Female		Black		July 4 1912		70		8:40p <sub>M</sub>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
S.C.		U.S.A.				Prince George's		43 Govt.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							
Lanham		Doctors' Hospital of Pr. Geo. Co.							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md		P.G.		Landover		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3107-7516 Ave	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Dean Brunson					Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS		
NO					None		577-346613 Walter Price Same 10313 E		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the colon</u> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Sepsis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
6/23/82		Perineal Fissure				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Reynaldo L. Leelacer</u>					22c. DATE SIGNED			22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
					7/21/82			22e. ADDRESS	
					8909 Old Branch Ave., Clinton, Md. 20735				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
		7-24-82		Harmony Cemetery		Landover P.G. Md			
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE RECEIVED BY REGISTRAR				
H.S. Washington 4925 Bonaughts Ave N.E.					JUL 28 1982				



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 9 1 2 9

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
EILEEN F. PRICE					July 26 1982					1058 AM
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female	White		12/15/21		60		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA				Prince Georges County MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Laurel		Greater Laurel Beltsville Hospital				Secretary-Fruit Growers				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS		
Md. Mont.				S.S.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12800 Poplar St.		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
Edward A. Peter		Elsie Leishear		None		577 24 5084		1337 Passage Dr. Odenton, Md. Patricia Wise (Daughter)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4100 IMMEDIATE CAUSE (a) Myocardial Infarction										
DUE TO, OR AS A CONSEQUENCE OF (b) Arterio sclerosis										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
		HOUR A.M. MONTH DAY YEAR								
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from July 15, 1982, to July 26, 1982, that (I) (we) last saw the deceased alive on July 19, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE				22c. DATE SIGNED		
HYO S. CHUNG				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				July 26, 1982		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS						
HYO S. CHUNG				7100 Contee Road Laurel, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE		
Cremation		7/27/82		Lee's Crematory		Wash.D.C.				
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Hines/Rinaldi 11800 N.H.Ave.S.S.Md.						JUL 29 1982		[Signature]		

MEDICAL CERTIFICATION

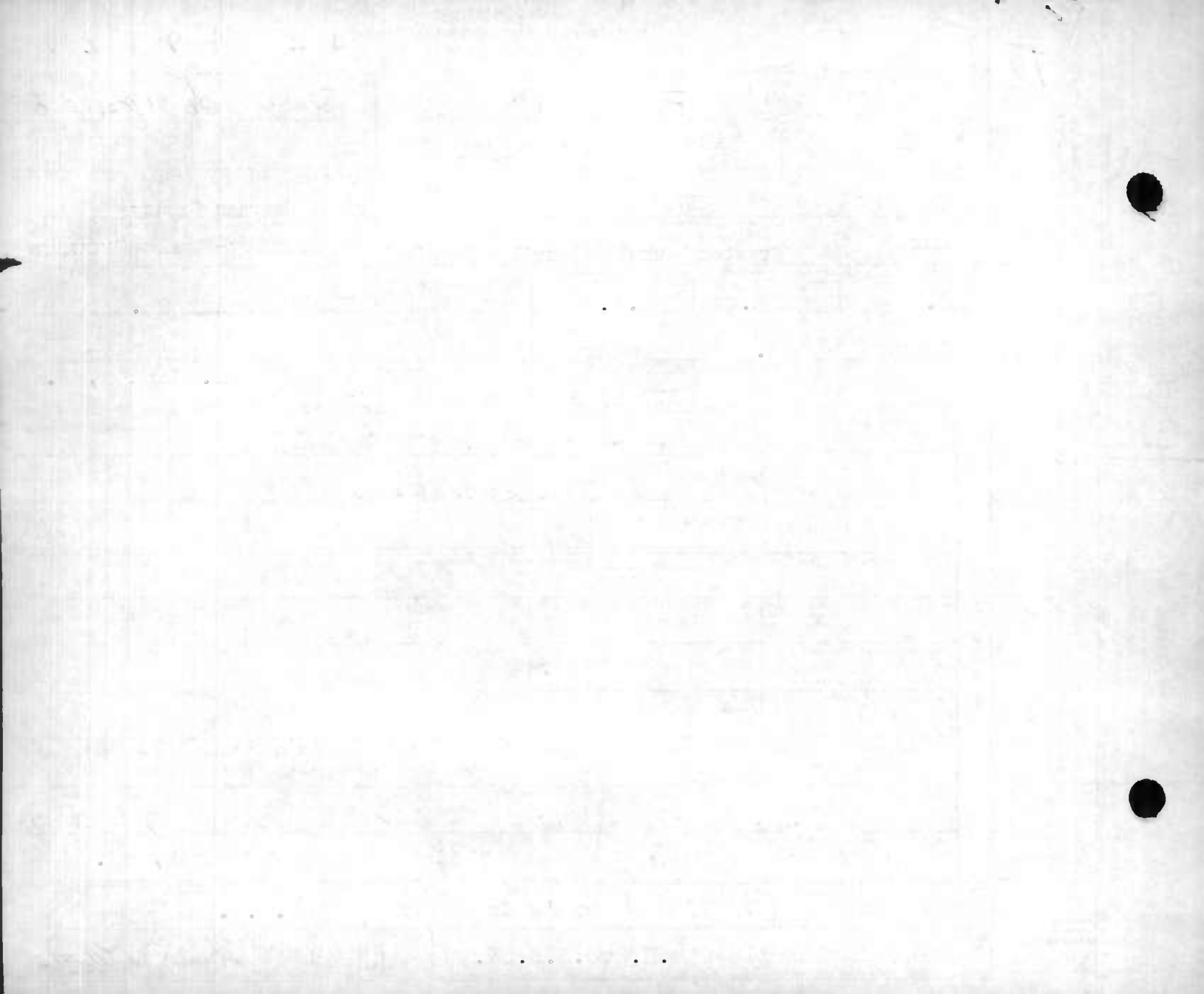
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health officer within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO. 8 2 1 9 1 3 0									
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR
IDA			QUEEN			07-25-82			4:05AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR	
Female		Black		Dec. 13, 1913		68		YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		U.S.A.				PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY	
CHEVERLY		PRINCE GEORGE'S GENERAL HOSPITAL				Unemployed		None	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
Md.			P.G. Upper Marl.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		
							Box 11 Queen Ann Br. Rd.		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST					FIRST MIDDLE LAST				
Anthony White					Elizabeth Deal				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			Unknown		James White-Same as # 13 above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) <u>Renal failure</u>									5 yrs
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Hypertension</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Diverticular abscess</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED	
5-4-82			Diverticular abscess			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		IN FINDING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED			
(IF EITHER, NOTIFY MEDICAL EXAMINER)			HOUR A.M. MONTH DAY YEAR			(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
			P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/9/1982</u> to <u>7/25/82</u> that (I) (we) lost saw the deceased alive on <u>7/24/82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE			DEGREE			22c. DATE SIGNED			
<u>A. ZHER</u>			MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
AZHER HUSSAIN			4917, Edgewood Road Chevy Chase MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial			7-29-82		Harmony Mem. Park		CITY OR TOWN COUNTY STATE		
							Highland Park, Md.		
24. FUNERAL DIRECTOR			25a. DATE REC'D BY REGISTRAR			25b. SIGNATURE			
NAME ADDRESS			AUG 6 1982			<u>[Signature]</u>			
H.S. WASHINGTON - 3045 4425 BURROUGHS AVE. N.E.									



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Venkatakrishna</b> <i>Venkatakrishna</i>		MIDDLE <b>Ramamurthy</b> <i>Ramamurthy</i>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 7 26 82 19		2b. HOUR 570 A M	
3. SEX <b>M</b>	4. RACE <b>Asian</b>	5. DATE OF BIRTH MONTH DAY YEAR 3 31 16	6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 7 26 82 19	2d. HOUR 570 A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>India</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Lanham</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Doctors Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Administrative assistant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Red Cross</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>New Carrollton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Venkatakrishna Ramamurthy</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nama Girl</b>		16. SOCIAL SECURITY NO. <b>579-88-9558</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579-88-9558</b>		17. INFORMANT ADDRESS <b>Ram Rajan-son 6113 85th Ave New Carrollton, Md. 20784</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE <b>Cardio respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Chronic renal failure</b> <b>ASVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes mellitus</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Said A. Daee, M.D.</b>		TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER		DATE SIGNED <b>7-26-82</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Said A. Daee, M.D.</b>		ADDRESS <b>4306 Pavia Ct. Mitchellville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>7-26-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C. 20002</b>	
24. FUNERAL DIRECTOR NAME <b>Lee Funeral Home</b>		ADDRESS <b>300-4th St. N.E. Wash. D.C. 20002</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 28 1982</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 2 1 9 1 3 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>EDWINA ANNA Reckert</b>				2a. DATE OF DEATH MONTH <b>7</b> DAY <b>14</b> YEAR <b>82</b>		2b. HOUR <b>5:35</b> M <b>P</b>	
3. SEX <b>Female</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>DEC.</b> DAY <b>20</b> YEAR <b>1889</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S</b> MD.	
10. CITY OR TOWN OF DEATH <b>HYATTSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CARROLL MANOR</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>CATHERS BURG</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>GEORGE</b> MIDDLE <b>MEYD</b> LAST <b>—</b>		15. MOTHER'S MAIDEN NAME FIRST <b>ANNA</b> MIDDLE <b>MILLER</b> LAST <b>—</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>229604554</b>	
17. INFORMANT <b>CATHARINE A. HEINE</b>		18. ADDRESS <b>SAME AS #13</b>		19. DATE OF OPERATION <b>Dec 13 1982</b>		20. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>METASTASIS OF ADENOCARCINOMA</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)		21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21e. INJURY OCCURRED <b>WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21g. LOCATION <b>LIBERT</b> CITY OR TOWN <b>—</b> COUNTY <b>—</b> STATE <b>—</b>		21h. DATE SIGNED <b>7/14/82</b>	
22a. I certify that (1) (this hospital) attended the deceased from <b>Dec 13 1982</b> to <b>July 14 1982</b> that (1) (was) last seen the deceased alive on <b>July 13 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated		22b. SIGNATURE <b>James J. Foster</b> DEGREE <b>—</b>		22c. ADDRESS <b>916-19TH ST. NW WASH. D.C.</b>		22d. DATE SIGNED <b>7/14/82</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>July 17 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVE T CEM</b>		23d. LOCATION CITY OR TOWN <b>WASH. D.C.</b> COUNTY <b>—</b> STATE <b>—</b>	
24. FUNERAL DIRECTOR NAME <b>DEVOI FUNERAL HOME</b> ADDRESS <b>WASH. D.C.</b>		25. REC'D. BY REGISTRAR <b>JUL 21 1982</b>		26. REGISTRAR'S SIGNATURE <b>—</b>		27. REGISTRAR'S OFFICE <b>—</b>	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19133	
1. DECEASED NAME (TYPE OR PRINT)		FIRST George		MIDDLE		LAST Redd		2b. DATE KNOWN OF DEATH MATED		2c. DATE PRONOUNCED DEAD	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Feb. 22, 1896		6. AGE (IN YEARS) LAST BIRTHDAY 86 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH P.G.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Unknown	
10. CITY OR TOWN OF DEATH Md.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10910 Exeter Ct. Keta		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Unknown		13a. STREET ADDRESS 10910 Exeter Court		13b. CITY OR TOWN Upper Marlboro	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM H. REDD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NELLIE BROWN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-38-3455		17. INFORMANT Mr. Vernon T. Christian/nephew/2811		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4960 Cardiorespiratory arrest (b) COPD (c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE SAID A. DAER M		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER		DATE SIGNED 7-23-82					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-28-82		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d. LOCATION CITY OR TOWN Suitland,		COUNTY Md.		STATE	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		26. NAME John T. Rhines Co., 3015 12th St. N.E., D.C. 20001					

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 9 1 3 4	
1- FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) CARRIE C. REEDER			2a. DATE OF DEATH MONTH DAY YEAR 07-09-82		2b. HOUR 11:40PM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Mar. 1, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD	
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Domestic
13a. STATE Maryland	13b. COUNTY P.G.	13c. CITY OR TOWN Aguasco	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 20709 Aguasco Rd, Aguasco, Md	
14. FATHER'S NAME FIRST MIDDLE LAST George Brooks		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Craig			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-30-7935		17. INFORMANT ADDRESS Elizabeth Reeder S/A	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) <u>Cardiac pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>perforated of viscous</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ca of colon to metastasis to liver pelvis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Cachexia</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 24</u> , 19 <u>82</u> , to <u>July 9</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>July 9</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>MEIYUN H. KO</u>		DEGREE M.D.		22c. DATE SIGNED 7/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MEIYUN H. KO		22e. ADDRESS P664H			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-14-82		23c. NAME OF CEMETERY OR CREMATORY St. Phillips Ch, Cem	
23d. LOCATION CITY OR TOWN Aguasco,		COUNTY P.G.		STATE Md	
24. FUNERAL DIRECTOR NAME Martell Adams		ADDRESS Aguasco, Maryland		25a. DATE REC'D. BY REGISTRAR JUL 21 1982	
				25b. SIGNATURE James Santhorn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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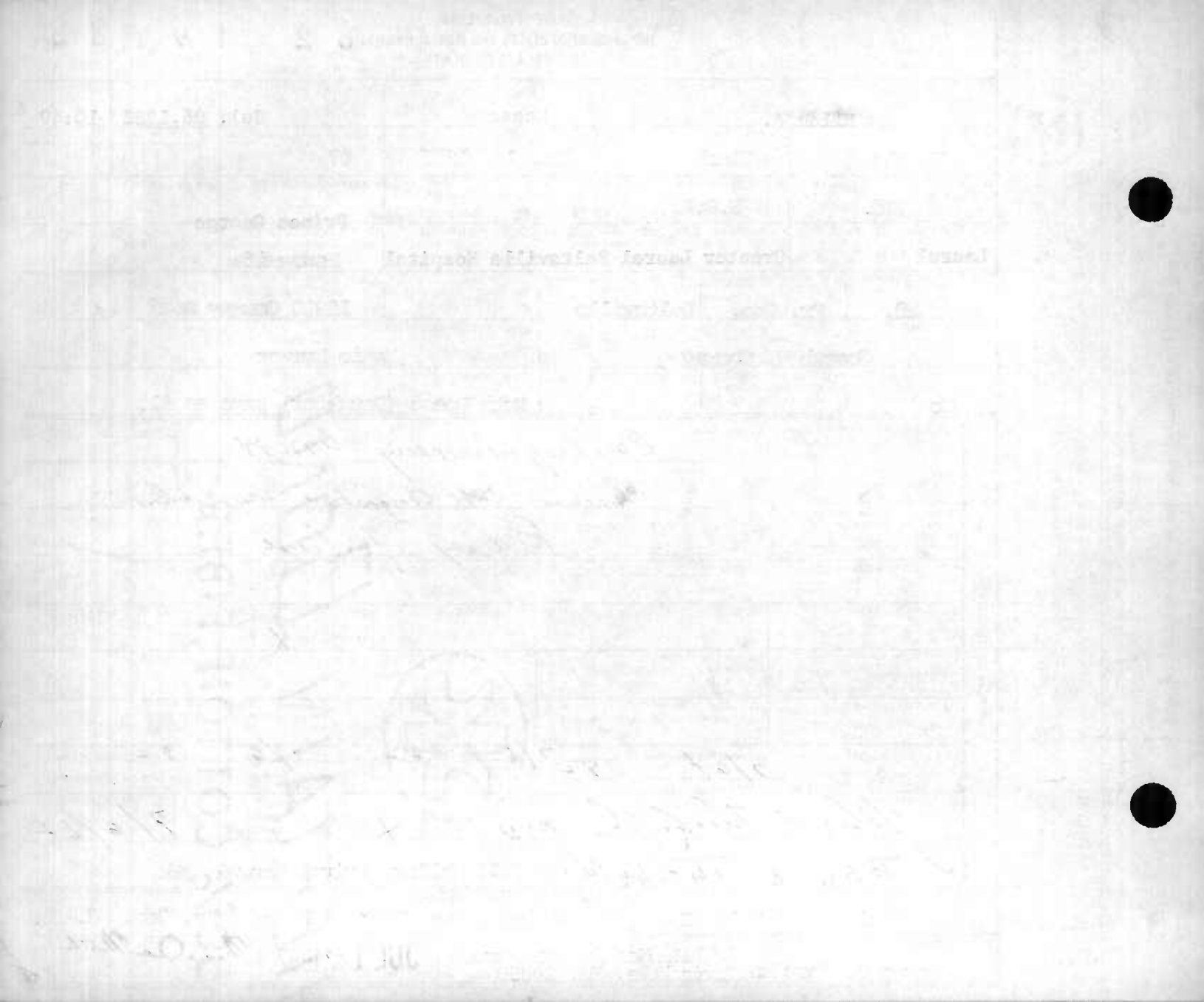
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 9 1 3 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Ellen A. Reese</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Jul. 06, 1982</b>		2b. HOUR <b>10:40<sup>M</sup></b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 14, 1895<sup>R</sup></b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS. MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD.	
10. CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Laurel Beltsville Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>				13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Beltsville</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph H. Conway</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mamie Brewer</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Ruth Reese (Daughter) same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>5860</b> IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Kidney failure</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/5</b> , 19 <b>82</b> , to <b>7/6</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>7/6</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John B Theobalds MD</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/6/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John B Theobalds</b>				22e. ADDRESS <b>9811 Mallard Drive, Laurel, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-10-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. National Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel, Pr. Geo. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b>				24b. ADDRESS <b>246 N. Washington Street Rockville, Md. 20850</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 12 1982</b>	
				25b. REGISTRAR'S SIGNATURE <b>Thomas D. North</b>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	1	9	1	3	6
1. FOR STATE REGISTRAR										CERTIFICATE OF DEATH						
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH MONTH DAY YEAR						
FIRST MARY MIDDLE ELLEN LAST RICKER										7-1-82						
3 SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS HOURS MIN.		
FEMALE			CAUCASIAN			AUG 12, 1900			81 YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH							
WASHINGTON, D.C.			U.S.A.						PRINCE GEORGE'S COUNTY MD.							
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
CLINTON			SOUTHERN MARYLAND HOSPITAL							BINDER			G.P.O.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13e. STREET ADDRESS							
MARYLAND			PRI. GEO.			FT. WASHINGTON			12004 BION DRIVE 20744							
14 FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
OWEN COONEY					MARGARET KELLY											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES AND OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO					17 INFORMANT ADDRESS						
NO					216-44-8818					OWEN J. RICKER SAME AS 13 SON						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
IMMEDIATE CAUSE (a) 2028 LOW Hodgkins lymphoma																
DUE TO, OR AS A CONSEQUENCE OF (b)																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a																
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from 6/29 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (we) did not view the body after death.										19 78 to 7/1 19 82 that (1) (we) lost						
22b. SIGNATURE					DEGREE					22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL					7/5/82			ARLINGTON NATIONAL			ARLINGTON VIRGINIA					
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901										25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 12 1982 Francis J. Collins						



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please notify the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5898.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					7 2 1 9 1 3 7				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
Gaetano Rigano					7 6 82 7:35 P <sub>M</sub>				
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 1, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 86		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.			
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR WHOLE WORKING LIFE) Plaster		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE Maryland					13b. COUNTY Prince Georges		13c. CITY OR TOWN Riverdale		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Riago					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 105 12 2339		17. INFORMANT ADDRESS Joseph Rigano (Same #13)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 5698 IMMEDIATE CAUSE (a) <u>ACUTE C2 BLEEDING</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>PERFORATED ULCER (DUODENAL)</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>COPD, ASPIRATION, AICUD</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-P.M.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION W-R-H			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6-7, 19 82, to 7-6, 19 82, that (I) (we) last saw the deceased alive on 7-6, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/1/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Keenan					22e. ADDRESS 6720 Riverdale Rd, Hyattsville Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/9/82		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.		
24. FUNERAL DIRECTOR NAME W.W. Chambers Co Riverdale Md.					25a. DATE REC'D. BY REGISTRAR JUL 12 1982				

MEDICAL CERTIFICATION

Black, W. H. 10-1-19

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 19138

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>George A. Robey</b>			2a. DATE KNOWN OF DEATH ESTIMATED MONTH <b>7</b> DAY <b>22</b> YEAR <b>82</b>		2b. HOUR <b>5:30</b> PM
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>May</b> DAY <b>7</b> YEAR <b>1897</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>85</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH <b>7</b> DAY <b>22</b> YEAR <b>82</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Riverdale</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN CITY OR TOWN, GIVE STREET ADDRESS) <b>Leland Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Foreman</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>	13c. CITY OR TOWN <b>Riverdale</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b>T.</b> LAST <b>Robey</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Sarah</b> MIDDLE <b>Osborne</b> LAST <b>Osborne</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes-Army</b>		16b. SOCIAL SECURITY NO. <b>577-36-8221</b>		17. INFORMANT <b>Gladys M. Robey</b>	
16c. (IF YES, GIVE WAR OR DATES) <b>W.W.I</b>		17. ADDRESS <b>Address Same as No# 13c.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASVD hx of MI</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <b>Said A. Daee M.D.</b>		TITLE (SPECIFY) <b>Deputy</b>		DATE SIGNED <b>7-23-82</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Said A. Daee, M.D.</b>		ADDRESS <b>5632 Annapolis Road, Suite # 4 Bladensburg, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-26-82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Maryland</b>
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 27 1982</b>		25b. REGISTRAR'S SIGNATURE <i>James J. Nathan</i>

54

White	Washington, D.C.	1914	Prince George's County
Riverdale			Prince George's County
Stuyvesant			Prince George's County
James			Prince George's County
Yonkers			Prince George's County

5032 Annapolis Road, Suite 4  
Baltimore, Maryland

7-22-21  
F. George's 2001 P.O. Box 1, Hyattsville, Md.

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
 EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE JUNEAU COUNTY CORONER  
 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 WITH YOUR FILES.  
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES.  
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PINE STREET,  
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										82		19139		REG. NO.																																																																															
1. DECEASED NAME (TYPE OR PRINT)						FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR																																																																									
TOMMIE						Hason		ROBINSON				7		1		82		19		8		M																																																																									
3. SEX		4. RACE		5. DATE OF BIRTH		MONTH		DAY		YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS		DAYS		IF UNDER 24 HRS. HOURS		MIN.		7c. DATE PRONOUNCED DEAD																																																																									
M		W		8		28		07		75		YRS.										7																																																																									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH																																																																																			
Alabama				USA								Prince Georges																																																																																			
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY																																																																													
Green belt						2v Laurel Hill						T.V. Repairman						Self-empl.																																																																													
13a. STATE												13b. COUNTY												13c. CITY OR TOWN												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												13e. STREET ADDRESS																																															
Maryland												Pr. Georges												Greenbelt												YES												2V Laurel Hill Road																																															
14. FATHER'S NAME												15. MOTHER'S MAIDEN NAME												16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)												16b. SOCIAL SECURITY NO.												17. INFORMANT												ADDRESS																																			
Andrew												Robinson												Ann												Cooper												Yes												Unknown												579-22-2202												Mrs. Mae Robinson, Greenbelt, MD.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																																													
4100 IMMEDIATE CAUSE (a) Cardiac arrest																																																																																															
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																																																																																															
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>																																																																											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																																																											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																																																																											
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																																																																															
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED																																																																											
SAID A. DASE M.D.										Deputy										7-1-82																																																																											
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																																																																																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION CITY OR TOWN COUNTY STATE																																																																	
Burial										July 3, 1982										Sunset Mem. Gardens										Spotsylvania, VA.																																																																	
24. FUNERAL DIRECTOR NAME										ADDRESS										25a. DATE REC'D. BY REGISTRAR										25. REGISTRAR'S SIGNATURE																																																																	
Charles F. B...										20678 Prince Frederick MD										JUL 7 1982										Frances Jean Nathan																																																																	

Serial

July 3, 1962 Sunset Inn, Cardona

Spotylvania, VA.

Yes

Unknown

579-22-2302 Mrs. Mae Robinson, Greenbelt, MD.

Andrew

Robinson

Ann

Cooper

Larryland Mr. George Greenbelt

2V Laurel Hill Road

T.V. Robinson Self-emp.

Prince Georges

USA

Algebra

Passon



Item 4 per phone 7/26/82 dad

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

19140

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR																																																																									
Hunter J. ROLAND								7-8 1982																																																																																	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR																																																																					
Male		Caucasian		3-17-10		72 YRS.						7-8 1982																																																																													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		7. BALTIMORE CITY OR COUNTY OF DEATH																																																																													
Maryland		USA				<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>																																																																															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY																																																																																			
Clinton		Southern Maryland		Retired		Auto Mech.																																																																																			
13a. STATE																		13b. COUNTY																		13c. CITY OR TOWN																		13d. INSIDE CITY LIMITS?																		13e. STREET ADDRESS																	
Md.																		Pr. George																		Friendly																		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																		10300 Roland Lane																	
14. FATHER'S NAME																		15. MOTHER'S MAIDEN NAME																																																																							
Alton																		Lillie																		White																																																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?																		16b. SOCIAL SECURITY NO.																		17. INFORMANT																		ADDRESS																																			
no																		none																		578-09-0896																		Elizabeth Roland same as item 13																																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																																							
PART I DEATH WAS CAUSED BY:																																																																																									
IMMEDIATE CAUSE (a)																		DUE TO, OR AS A CONSEQUENCE OF																																																																							
4292																		Intermittent cardiovascular disease																																																																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																		(b)																		DUE TO, OR AS A CONSEQUENCE OF																																																					
																		(c)																																																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																																																																																									
19a. DATE OF OPERATION																		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																		20. AUTOPSY?																																																					
																																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH																		21b. TIME OF INJURY																		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																																					
																		HOUR A.M. MONTH DAY YEAR																																																																							
																		P.M. 19																																																																							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)																		21f. LOCATION																																																					
																																				STREET CITY OR TOWN COUNTY STATE																																																					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:																		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																																																							
ACTUAL SIGNATURE																		TITLE (SPECIFY)																		DATE SIGNED																																																					
Augusto P. Rodriguez																		Deputy																		7-8-82																																																					
EXAMINER'S NAME (TYPE OR PRINT)																		ADDRESS																																																																							
Augusto P. Rodriguez M.D.																		5009 Rayburn Ct., Temple Hills, Md.																																																																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)																		23b. DATE																		23c. NAME OF CEMETERY OR CREMATORY																		23d. LOCATION																																			
Burial																		7/12/82																		St. John Episcopal Ch.																		Broadcreek																																			
																																																						COUNTY STATE																																			
																																																						Md.																																			
24. FUNERAL DIRECTOR																		25a. DATE REC'D. BY REGISTRAR																		25b. REGISTRAR'S SIGNATURE																																																					
G. P. Kalas																		JUL 16 1982																		James J. VanHouten																																																					
6160 Oxon Hill Rd. Oxon Hill, Md.																																																																																									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

C. P. Kales 6150 Oxon Hill Rd. Oxon Hill, Md.

Burial

7/12/82

St. John Episcopal Ch. Frederick

Md.

no

none

478-02-0896

Elizabeth Roland same as item 18

Alton

Roland

Billie

White

10300 Roland Lane

x

Friendly

Fr. George

Md.

USA

Maryland

Retired

Auto pool.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 2 1 9 1 4 1			
FOR 1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Tessie N. Rossey				2a. DATE OF DEATH MONTH DAY YEAR July 18, 1982		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2-27-1898		6. AGE [IN YEARS (LAST BIRTHDAY)] 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Beltsville	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Haines				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 209-07-1227		17. INFORMANT Erma E. Schaff same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident and</u> <u>4360</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Surgeon Disorder 2' to @</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Constrictive Heart Failure</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from <u>7-13</u> 19 <u>82</u> to <u>7-18</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>7-18</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Maneywala				DEGREE MD		22c. DATE SIGNED 7-18-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B.G. Maneywala, MD.				22e. ADDRESS 14201 Laurel Park Dr Laurel Md 20701			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-21-1982		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Strattanville Clarion Pa.	
24. FUNERAL DIRECTOR NAME Donald V. Borgwardt Port Republic, Md.				25a. DATE REC'D. BY REGISTRAR JUL 23 1982			
				25b. REGISTRAR'S SIGNATURE Rene G. [Signature]			

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.



1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR   |  |  |  |   |  |   |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |
| REG. NO.  |  |  |  |   |  |   |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  |   |  | 2a DATE OF DEATH  |  | 2b HOUR  |  |
| BESSIE MAE ROWLES   |  |  |  |   |  | JULY 4, 1982  |  | 5:35pM   |  |
| 3. SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | IF UNDER 1 YEAR  |  |
| FEMALE  |  | WHITE  |  | JULY 3 1907   |  | 75  |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |  |  |
| NORTH CAROLINA  |  | UNITED STATES  |  |   |  | PRINCE GEORGE'S COUNTY MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)        |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| ANDREWS AFB   |  | MALCOLM GROW USAF MEDICAL CENTER   |  |   |  | HOUSEWIFE   |  | N/A  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE CAMP OR COMMISSION)   |  |  |  |   |  |   |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |
| MARYLAND  |  | PRINCE GEORGE'S  |  | SPRINGS   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 5009 THUMAN DRIVE  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |  |  |
| DANIEL OSCAR MOORE  |  |  |  | MATTIE ELIZABETH JONES  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO   |  | 17. INFORMANT ADDRESS   |  |  |  |
| NO  |  |  |  | 238/14/3885   |  | LUCY Y. MORTON WEIDEMEYER 614 CROCUS DR. ROCKVILLE, MD 20507        |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 7991 IMMEDIATE CAUSE (a) <i>X respiratory failure</i>   |  |  |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |  |  |   |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost   |  |  |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |   |  |  |  |
|   |  | P.M. 19  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION   |  |   |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 9 1982, to JULY 4 1982, that (I) (we) lost saw the deceased alive on JULY 4 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE  |  |   |  | 22c. DATE SIGNED   |  |
| <i>X Douglas P. Clark</i>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  |   |  | 4 July 82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |   |  |  |  |
| DOUGLAS P. CLARK, CAPT., USAF   |  |  |  | Box 3432 MCMC Andrews AFB   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |  |  |
| BURIAL  |  | 7/8/82   |  | TRINITY CEM.  |  | CHOCOWINITY BEAUFORT N.C.   |  |  |  |
| 24 FUNERAL DIRECTOR   |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| LEE FUNERAL HOME CLINTON MARYLAND   |  |  |  | JUL 6 1982  |  | Charles J. Nathan   |  |  |  |

1950



1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |   |  | 8 2 1 9 1 4 3            |     |   |          |                                   |  |
|---|--|--|--|--|--|---|--|---|--|--------------------------|-----|---|----------|-----------------------------------|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |  |  |   |  |   |  |                          |     |   |          |                                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2. DATE OF DEATH  |  | MONTH                    | DAY | YEAR  | 2b. HOUR |                                   |  |
| Rebecca E. Rudkin   |  |  |  |  |  |   |  | July 30, 1982   |  |                          |     |   | 3:23 PM  |                                   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR  |  | 8. IF UNDER 24 HRS       |     |   |          |                                   |  |
| F   |  | White  |  | May 8, 1902  |  | 80  |  | MONTHS  |  | DAYS                     |     | HOURS MIN.  |          |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |  |                          |     |   |          |                                   |  |
| Virginia  |  | USA  |  |  |  | Prince George County MD.  |  |   |  |                          |     |   |          |                                   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |   |  |   |  |                          |     | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |          | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Laurel  |  | Greater Laurel Beltsville Hospital   |  |  |  |   |  |   |  |                          |     | Clerk   |          | US Govt                           |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS      |     |   |          |                                   |  |
|   |  | Md   |  | Howard   |  | Laurel  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 9236 Whiskey Bottom Road |     |   |          |                                   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO   |  | 17. INFORMANT   |  | ADDRESS                  |     |   |          |                                   |  |
| John Francis Pope   |  | Caroline Simpson   |  | no   |  | 219 18 3026   |  | Kenneth Rudkin same as above  |  |                          |     |   |          |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY  |  |  |  |  |  |   |  |   |  |                          |     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |          |                                   |  |
| 5715 IMMEDIATE CAUSE (a) Acute hemorrhagic jejunitis  |  |  |  |  |  |   |  |   |  |                          |     |   |          |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Micronodular cirrhosis   |  |  |  |  |  |   |  |   |  |                          |     |   |          |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |   |  |   |  |                          |     |   |          |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |   |  |                          |     |   |          |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                          |     |   |          |                                   |  |
|   |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                          |     |   |          |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED   |  | 21d. PLACE OF INJURY  |  |   |  |                          |     |   |          |                                   |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  | P.M. 19  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                      |  |   |  |                          |     |   |          |                                   |  |
| 21e. INJURY OCCURRED  |  | 21f. LOCATION  |  | 21g. LOCATION  |  |   |  |   |  |                          |     |   |          |                                   |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>   |  | STREET   |  | CITY OR TOWN COUNTY STATE  |  |   |  |   |  |                          |     |   |          |                                   |  |
| AT WORK <input type="checkbox"/>  |  |  |  |  |  |   |  |   |  |                          |     |   |          |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 1978 to July 30, 1982, that (I) (we) last saw the deceased alive on July 30, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |  |                          |     |   |          |                                   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED  |  |   |  |                          |     |   |          |                                   |  |
| W.A. Warren   |  |  |  |  |  | 31 July 1982  |  |   |  |                          |     |   |          |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |   |  |                          |     |   |          |                                   |  |
| W.A. Warren   |  | 321 Prince George St Laurel, Md 20701  |  |  |  |   |  |   |  |                          |     |   |          |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | 23e. LOCATION   |  |                          |     |   |          |                                   |  |
| Burial  |  | August 2, 1982   |  | Meadowridge Mem Park   |  | Dorsey, Maryland  |  | CITY OR TOWN COUNTY STATE   |  |                          |     |   |          |                                   |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |   |  |                          |     |   |          |                                   |  |
| NAME Donaldson Funeral Home, Laurel, Md   |  | AUG - 5 1982   |  | John J. Lander   |  |   |  |   |  |                          |     |   |          |                                   |  |

BP



Neuroendocrine system  
Neuroendocrine system

X

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by code.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |  |  |   | 8 2 1 9 1 4 4<br>CERTIFICATE OF DEATH      |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  |   | 2a. DATE OF DEATH                          |   |  |   |  |
| FIRST MIDDLE LAST<br><b>Bertha Elenore Scott</b>  |  |  |  |   | MONTH DAY YEAR HOUR<br><b>July 19 1982</b> |   |  |   |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb 15 1891</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>91</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>md</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George</b>                                    |  | 10. IF UNDER 24 HRS<br>HOURS MIN<br><b>MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hyattsville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MADISON MANOR Nursing Home</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>md</b>   |  | 13b. COUNTY<br><b>A.A.</b>   |  | 13c. CITY OR TOWN<br><b>ANNAPOLIS</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>Unknown</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MANCIE COOK</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JANE SCALES</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-54-3795</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Charlotte Johnson 300 E. CHESAPEAKE AVE</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): <b>Renal Failure</b><br>2859<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b): <b>Anemia Chronic Renal</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c): <b>Infect Inflection Hypertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Degenerative joint disease</b>   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>N/A</b>  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-8</b> 19 <b>81</b> , to <b>7-19</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>7-19</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>R. A. Hicks</b>  |  |  |  | DEGREE<br><b>Attending Physician</b>  |  |   |  | 22c. DATE SIGNED<br><b>7/19/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAKESH ARORA</b>  |  |  |  | 22e. ADDRESS<br><b>2231 SUPERIOR LN<br/>BOWIE MD 20715</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>July 23 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Brewer Hill Cem</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ANNAPOLIS A.A. md</b>                          |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 26 1982</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>C.E. Hicks</b>   |  | ADDRESS<br><b>1922 forest Drive</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James G. ...</b>   |  |   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |   |  |  |   | 7 2 1 9 1 4 5 |   |  |  |                                  |  |
|--|--|--|---|--|--|---|--|--|---|---------------|---|--|--|----------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  | REG. NO.  |  |  |   |  |  |   |               |   |  |  |                                  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST<br>EMIL   |  |  | MIDDLE<br>(NMN)   |  |  | LAST<br>SEIBEL  |               |   | 2r. DATE OF DEATH<br>MONTH DAY YEAR<br>JULY 27, 1982 |  | 2s. HOUR<br>11:10 PM             |  |
| 3. SEX<br>MALE   |  |  | 4. RACE<br>WHITE  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 14, 1904   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77   |               |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                    |  | 8. IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Germany   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince Georges MD                                       |               |   |  |  |                                  |  |
| 10. CITY OR TOWN OF DEATH<br>Adelphi   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS)<br>Manor Care Nursing Home |  |  |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Chef                        |               |   | 12b. BUSINESS OR INDUSTRY<br>Marriott Corporation    |  |                                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Prince Geo.  |  |  | 13c. CITY OR TOWN<br>Beltsville   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |               |   | 13e. STREET ADDRESS<br>11206 Cherry Hill Road        |  |                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Seibel   |  |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown  |  |  |   |               |   |  |  |                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>189 03 4274  |  |  | 17. INFORMANT<br>ADDRESS<br>Robert E. Seibel Same as #13 (Son)  |  |  |   |               |   |  |  |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Recurrent CVA</u><br><u>4360</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>HBP</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Seizure Disorder</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |  |   |  |  |   |               |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>7/82 |  |                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Hypothyroidism, Diverticulosis, ASCVD, Cerebrovascular Disease, Diabetes Mellitus</u>  |  |  |   |  |  |   |  |  |   |               |   |  |  |                                  |  |
| 19a. DATE OF OPERATION<br>None   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |                                  |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>NO   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |               |   |  |  |                                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |               |   |  |  |                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-25-80</u> , 19 <u>80</u> , to <u>7/27/82</u> , 19 <u>82</u> , that (I) <u>never</u> lost saw the deceased alive on <u>7/22/82</u> , 19 <u>82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>have</u> (did not) view the body after death.  |  |  |   |  |  |   |  |  |   |               |   |  |  |                                  |  |
| 22b. SIGNATURE<br><u>HBPatrick MD</u>  |  |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |   |               |   | 22c. DATE SIGNED<br>7/28/82                          |  |                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>G B Patrick MD</u>   |  |  |   |  |  | 22e. ADDRESS<br><u>9221 Colesville Rd Silver Spring, Md 20910</u>   |  |  |   |               |   |  |  |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>7/30/82  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Denison Cemetery  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Fortyfort Prince Georges Maryland                 |               |   |  |  |                                  |  |
| 24. FUNERAL DIRECTOR<br>Name <u>Francis Gasch's Sons Funeral Home, P.A.</u><br>Address <u>Hyattsville, Maryland</u>  |  |  |   |  |  | 25. DATE REC'D. BY REGISTRAR<br>JUL 30 1982 REGISTRAR'S SIGNATURE <u>[Signature]</u>  |  |  |   |               |   |  |  |                                  |  |

|         |                           |   |                                   |    |
|---------|---------------------------|---|-----------------------------------|----|
| Germany | W.S. 4.                   | x | Prince Georges                    | 77 |
| Adelphi | Macdonald re Nursing Home |   | Chief                             |    |
| Marvann | Prince Geo. Belleville    | x | 11308 Cherry Hill Road            |    |
| William | Seibel                    |   | Unknown                           |    |
| No      | 188 07 4274               |   | Robert E. Seibel same as 17 (son) |    |

188 07 4274  
 Robert E. Seibel same as 17 (son)  
 11308 Cherry Hill Road  
 Chief  
 Prince Georges  
 77  
 W.S. 4.  
 x  
 Macdonald re Nursing Home  
 Adelphi  
 Marvann  
 Prince Geo. Belleville  
 x  
 William  
 Seibel  
 Unknown  
 188 07 4274  
 No

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD SIGN AND DATE THE CERTIFICATE. WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM, P.M. 3, RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                      |  |  |  |                                    |   |  |  |  | REG. NO. 19146  |  |
|--|----------------------|--|--|--|------------------------------------|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Julaina SELF</b>   |                      |  |  |  |                                    |   |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> 7 3 19 82 |  |
| 3. SEX <b>Female</b>   | 4. RACE <b>Black</b> | 5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 1 1960</b>   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>21 YRS.</b> | IF UNDER 1 YR. MONTHS DAYS HOURS MIN   | 7c. DATE PRONOUNCED DEAD 7 4 19 82 | 2d. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> 7 3 19 82                                   |  | 2e. HOUR 8:30  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Trinidad</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County</b>                                      |  | MD   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Oxon Hill</b>   |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>516 Wilson Bridge Dr.</b> |  |  |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse</b>                              |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE <b>MD.</b>  |                      | 13b. COUNTY <b>P.G.</b>  |  | 13c. CITY OR TOWN <b>Oxon Hill</b>   |                                    | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 13e. STREET ADDRESS <b>516 Wilson Bridge Dr.</b>                                 |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Leo O. Self</b>   |                      |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marima M. Self</b>   |                                    |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |                      |  |  | 16b. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT ADDRESS <b>Wash. D. Marima Self 5024 9th St. N.W.</b>                                     |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Strangulation</b><br>9630<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                              |                      |  |  |  |                                    |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |                      |  |  |  |                                    |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |                      |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                    |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                      |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. 7-3- 1982</b>   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Subject strangled.</b> |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                      |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>apt.</b>  |                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>516 Wilson Bridge Dr., Oxon Hill, P.G. Md.</b>        |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                      |  |  |  |                                    |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Ann M. Dixon</b>   |                      |  |  | TITLE (SPECIFY) <b>Assistant</b>   |                                    |   |  | DATE SIGNED <b>7-5-82</b>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |                      |  |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>   |                                    |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |                      | 23b. DATE <b>7-12-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Arima Cemetery</b>   |                                    | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arima Prince George's County Md.</b>                         |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Johnson + Jenkins</b> ADDRESS <b>Wash. D.C. 716 Kennedy St. N.W.</b>  |                      |  |  | 25a. DATE RECEIVED BY REGISTRAR <b>JUL 12 1982</b>   |                                    |   |  |  |  |   |  |



RECEIVED  
JUL 10 1964  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with vital records after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1. STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Sylvia R Sharp  |  | 2a. DATE OF DEATH<br>MONTH / DAY / YEAR<br>7 / 31 / 82  |   | 3b. HOUR<br>11:30 P.M.  |   |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH / DAY / YEAR<br>March 6, 1897   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.  |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince George County MD.                                |   |
| 10. CITY OR TOWN OF DEATH<br>Laurel  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Greater Laurel Nursing Home |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |   | 12b. KIND OF BUSINESS OR INDUSTRY                 |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Dundalk  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>late August Becker   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>late Erna  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>213 12 0544   |   | 17. INFORMANT<br>ADDRESS<br>Mrs Chas. McLamb 3225 Greenway 21043                                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4275 IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Dementia, (R) ribular fracture</u> |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>? |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |   |   |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/20/82</u> 19____, to <u>7/31/82</u> 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |   |
| 22b. SIGNATURE<br><u>L. A. Casas</u>   |  | DEGREE<br><u>COVERING FOR G. COMPTON</u>  |   | 22c. DATE SIGNED<br>7/31/82   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LUISA CASAS FOR G. COMPTON  |  | 22e. ADDRESS<br>1042 WEST ST. LAUREL MD 20707   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Aug 4, 1982  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Balto. Nat'l  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Harry H Witzke 4112 Columbia RD   |   |   |   |
| DATE REC'D. BY REGISTRAR<br>AUG - 3 1982   |  | REGISTRAR'S SIGNATURE<br>Charles Santhos  |   |   |   |

4.2.1

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILE THE CERTIFICATE WITH THE DIVISION OF VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

TO THE FUNERAL DIRECTOR: EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO. 19148   |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Paul Matthew Shay</b>   |  |  |  |  |  |  |  |  |  | 2b. DATE KNOWN OF DEATH <b>7 23 1982</b>   |  |
| 3. SEX <b>Male</b> 4. RACE <b>White</b> 5. DATE OF BIRTH <b>March 20, 1910</b> 6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS. 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>            |  |  |  |  |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD <b>7 23 1982</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>Greenbelt</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9011 Breezewood Terrace Apt-102</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Coal Mine Inspector</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 13a. STATE <b>Maryland</b> 13b. COUNTY <b>P.G.</b> 13c. CITY OR TOWN <b>Greenbelt</b> 13d. INSIDE CITY LIMITS? <b>YES</b> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>9011 Breezewood Terr. Apt-102</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME <b>Daniel Shay</b> 15. MOTHER'S MAIDEN NAME <b>Ellen White</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> 16b. SOCIAL SECURITY NO. <b>289-09-2537</b> 17. INFORMANT <b>Mrs. Carla Jo Bielaski</b> ADDRESS <b>4971 Little Falls Rd. Arlington, Va.</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4408</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>hx of ASVD lung Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                      |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION _____ 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____ 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH _____ 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR _____ P.M. 19 _____ 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) _____  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) _____ 21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____   |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Said A. Daee, M.D.</b> TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER ADDRESS <b>5632 Annapolis Road, Suite # 4 Bladensburg, Maryland</b>   |  |  |  |  |  |  |  |  |  | DATE SIGNED <b>7-23-82</b>   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Said A. Daee, M.D.</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>7-26-82</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b> 23d. LOCATION CITY OR TOWN <b>Clinton</b> COUNTY <b>P.G.</b> STATE <b>Maryland</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b> ADDRESS _____   |  |  |  |  |  |  |  |  |  | 25a. DATE RECD. BY REGISTRAR <b>JUL 27 1982</b> 25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b> |  |



White

U.S.A.

x

Prince George's County

Greenland

-

the Inspector I. S. Davis

Greenland

x

Will Greenwood Terr. 401-103

Greenland

Green

Ellen

White

280-00-2737

Mrs. Marie Jo Michael, 101 Arlington St.



Said A. Dace, W.D.

Windsor, Maryland

Resurrection Cemetery Clinton Md. Maryland

W. George's Sons W.H. P.A. Hyattsville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |   |  |  |  |  |  |
|--|--|---|--|---|---|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |   |  |   |   |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |   |   |  |  |  |  |  |
| REG. NO. 8 2 1 9 1 4 9   |  |   |  |   |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lucille C. SIMMONS</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 4, 1982</b>                            |  | 2b. HOUR<br><b>11:00a</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>November 18, 1895</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Louisiana</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince-Georges</b> MD.                    |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hyattsville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sacred Heart Home, Inc.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>             |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Louisiana</b>   |  |   |  |   | 13b. COUNTY <b>Caddo</b>  |  | 13c. CITY OR TOWN<br><b>Shreveport</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        |  |
| 14. FATHER'S NAME<br>FIRST <b>Levi</b> MIDDLE <b>Patrick</b> LAST <b>Carter</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Catherine</b> MIDDLE <b>C.</b> LAST <b>Fahey</b> |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>439-86-3464</b>   |  | 17. INFORMANT<br>ADDRESS <b>145 11th. St. N.E.</b><br><b>Richard N. Holwile Washington, D.C.</b>  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4140</b> IMMEDIATE CAUSE (a) <b>gram neg sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>multiple decubiti</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cerebral Vascular Disease</b>   |  |   |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>48<sup>h</sup></b><br><b>3 mos.</b><br><b>years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>CA of Breast, ASHD, CVD</b>   |  |   |  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-20</b> , 19 <b>80</b> , to <b>7-4</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>July 3</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>J. M. Kuster</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   |  |  | 22c. DATE SIGNED<br><b>July 4, 1982</b>                          |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. J. M. KHATRI</b>   |  |   |  | 22e. ADDRESS<br><b>6525 BELCREST RD Hyattsville, Md 20782</b>   |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>July 8, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Forest Park - West</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Shreveport Caddo Louisiana</b>      |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>  |  |   |  | 25a. DATE RECD. BY REGISTRAR<br><b>JUL 9 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                     |  |  |  |  |



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 1 9 1 5 0  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |  |  | REG. NO.   |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>T O N I O   |  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>7 - 24 - 82  |  |  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>W H I T E  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 - 28 - 09  |  | 2b HOUR<br>3:08 P.M.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>G E R M A N Y   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  |
| 10 CITY OR TOWN OF DEATH<br>U P P E R M A R I A P O L I S   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>M A N A G E R C A R E L A R G O |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>P R. G E O R G E S M D.                                     |  |  |  |
| 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>H O R S E T R A I N E R - R e t i r e d  |  |  |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br>M D.  |  | 13b. COUNTY<br>P. G.   |  | 13c. CITY OR TOWN<br>L A U R E L   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14 FATHER'S NAME<br>F I R S T M I D D L E L A S T<br>J o h a n n S i m o n  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>F I R S T M I D D L E L A S T<br>H e l e n a K u c h e n n e i s t e r |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Y E S  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W N I I  |  | 17 INFORMANT<br>A D D R E S S<br>P O B o x 412<br>Anton K. Richter Stony Brook, N.Y.               |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) C A R C I N O M A S C A L P<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) B R A I N M E T A S T A S I S<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>1734<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>74 HRS<br>74 HRS |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                      |  |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>M E M E A D E M M<br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  | 22c. DATE SIGNED   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>N e i l A m e a d e  |  |  |  | 22e. ADDRESS<br>6501 L A N D O V E N R D C H A N N Y M D   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>7-26-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft. Lincoln  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>Brentwood P R. Geo. M D.   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Beall Funeral Home<br>16,000 Annapolis Rd.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 28 1982<br>REGISTRAR  |  |  |  |

MEDICAL CERTIFICATION





15901 Bldg. 1100  
 15901 Bldg. 1100  
 15901 Bldg. 1100

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 9 1 5 1

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><u>Daniel</u>   |  | FIRST<br><u>SKINNER</u>  |  | LAST<br><u>SKINNER</u>   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><u>7</u> <u>1</u> <u>82</u>                 |  | 2b HOUR<br><u>8:25</u> A.M.                                 |  |
| 3 SEX<br><u>male</u>  |  | 4 RACE<br><u>Black</u>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><u>9</u> <u>2</u> <u>1907</u>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><u>74</u> YRS.                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br>IF UNDER 24 HRS |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Maryland</u>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><u>Prince George's</u> MD.                 |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><u>Adelphi</u>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Manor Care Nursing Center</u> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Farming</u> |  | 12b KIND OF BUSINESS OR INDUSTRY                            |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <u>Md</u> 13b COUNTY <u>P.G</u> 13c CITY OR TOWN <u>Brandywine</u> 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e STREET ADDRESS <u>19011 Cream Rd</u> <u>20613</u> |  |  |  |  |  |   |  |   |  |

|  |  |   |  |
|--|--|---|--|
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Daniel</u> <u>Skinner</u>            |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Louise</u> <u>Butler</u> |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>NO</u> |  | 16b SOCIAL SECURITY NO<br><u>217-30-6928</u>                                |  |
| 17 INFORMANT<br><u>Mary Ellington</u>  |  | ADDRESS<br><u>1913 Lakewood St. Suitland Md 21076</u>                       |  |

|  |  |  |
|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>1991</u> IMMEDIATE CAUSE (a) <u>metastatic Adenocarcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>3 months</u> |
|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>19</u>           |  | 21c HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |

22a I certify that (I) (this hospital) attended the deceased from 6/15 1982 to 7/1 1982, that (I) (we) lost  
saw the deceased alive on 6/15 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

|   |  |                     |  |  |  |                                  |  |
|---|--|---------------------|--|--|--|----------------------------------|--|
| 22b SIGNATURE<br><u>Don H. Yablonsky</u>                        |  | DEGREE<br><u>MD</u> |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br><u>7/1/82</u> |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Don H. Yablonsky</u> |  |                     |  | 22e ADDRESS<br><u>10300 Greenbelt Rd, Seabrook, Md.</u>  |  |                                  |  |

|  |  |                           |  |   |  |  |  |
|--|--|---------------------------|--|---|--|--|--|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u> |  | 23b DATE<br><u>7-6-82</u> |  | 23c NAME OF CEMETERY OR CREMATORY<br><u>Christ Un. Meth Ch. Agrasco</u> |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>P.G.</u> <u>Md</u> |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><u>Martell Adams</u>          |  |                           |  | ADDRESS<br><u>Agrasco Md 20608</u>                                      |  | 25a DATE REC'D BY REGISTRAR<br><u>JUL 21 1982</u>                  |  |
| 25b REGISTRAR'S SIGNATURE<br><u>Francis J. Nathan</u>        |  |                           |  |   |  |  |  |



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DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Golden C. SMILEY  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 31, 1982                               |  | 2b. HOUR<br>7:06 a.m.  |
| 3. SEX<br>Male  | 4. RACE<br>Cauc.  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 23, 1908   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince George's MD.                        |  |  |
| 10. CITY OR TOWN OF DEATH<br>Lanham   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Doctors' Hosp. of P. G. County |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. BusDriver | 12b. KIND OF BUSINESS OR INDUSTRY<br>D.C. Trans                                      |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |   |   | 13b. COUNTY<br>P.G.  | 13c. CITY OR TOWN<br>Bowie   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Smiley   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alberta (unknown)                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----<br>577-07-6603   | 17. INFORMANT<br>ADDRESS<br>Bowie<br>Clara J. Kircher, 2507 Kitmore La., Md.       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardio pulmonary Arrest</i><br>4960<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Severe chronic obstructive Lung</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>disease and congestive heart Failure</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><i>alcoholic Liver disease</i>  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>6/29</i> , 19 <i>82</i> , to <i>7/31</i> , 19 <i>82</i> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>7/30</i> , 19 <i>82</i> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we did) (did not) view the body after death. |   |   |  |  |  |
| 22b. SIGNATURE<br><i>R. Dakheel</i>   |   | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>7/31/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Riad AL Dakheel, M.D.</i>   |   | 22e. ADDRESS<br><i>14300 Gallant Fox Ln. Bowie, MD, 20715</i>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |   | 23b. DATE<br>Aug. 3, 1982   | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft. Lincoln Cem.                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brentwood, Maryland  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Beall Funeral Home  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>AUG 6 1982  |  |  |
| 16000 Annapolis Rd., Bowie, Md.   |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i>                                |  |  |

MEDICAL CERTIFICATION

29

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BP

0505

no 577-07-8603 Clara J. Kitcher, 2507 Kilmore Lane, Bowie  
 John Smiley Alberta (unknown)  
 Maryland P.B. Bowie  
 Maryland U.S.A.  
 Me C. uc. Aug. 23, 1908 W 73

15000 Annapolis Rd., Bowie, Md.  
 3211 Federal Road  
 Aug. 3, 1902 Ft. Lincoln Com. Brentwood, Maryland  
 1902

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |  |  |  |  | 7 2 1 9 1 5 3  |          |  |
|--|--|---|--|---|--|--|--|--|--|--|----------|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | CERTIFICATE OF DEATH   |  |  |  |  |  | REG. NO. |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>KATIE W SMITH  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>07 28 82  |  |  | 2b. HOUR<br>3 A.M.   |  |  |          |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Negro  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 4 1896  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGES MD.                 |  |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br>CHEVERLY  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PRINCE GEORGES GENERAL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>At Home   |  |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   | 13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Pr George   |  | 13c. CITY OR TOWN<br>Forrestville  |          |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   | 13e. STREET ADDRESS<br>3213 Walters Lane   |  |  |  |  |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Minor Wallace  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Fannie Turner   |  |  |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>228-66-7962T  |  | 17. INFORMANT<br>ADDRESS<br>Sam H. Smith, Sr. Son Same as item #13             |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) SEPSIS<br>4280<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) MASSIVE DECUBITUS ULCER (MELASAR) 2 mos<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) CONGESTIVE HEART FAILURE (OVERDOSE) 4 yrs |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>48 H   |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>CHRONIC RENAL FAILURE  |  |   |  |   |  |  |  |  |  |  |          |  |
| 19a. DATE OF OPERATION   |  |   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  |   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |          |  |
| 22a. I certify that (1) this hospital attended the deceased from March 19 82 to 7/27 82, that (2) I (we) last saw the deceased alive on 7/27 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (and) did not view the body after death.               |  |   |  |   |  |  |  |  |  |  |          |  |
| 22b. SIGNATURE<br>P. Schussler MD  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br>7/28/82  |  |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>P. Schussler MD   |  |   |  |   | 22e. ADDRESS<br>7500 GREENWAY CRT DR GREENBELT MD 20770  |  |  |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   |  |   | 23b. DATE<br>7/31/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Smith Family                             |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>RFD #1 Schuyler, Va  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Cunningham Funeral Home  |  |   |  |   | Walter J. Holt<br>Alexandria, Va.  |  |  | 25a. DATE REC'D. BY REC'D. PARTY<br>AUG 5 1982                                       |  |  |          |  |



UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION  
NATIONAL WATER RESEARCH INSTITUTE  
1415 G STREET, N.W.  
WASHINGTON, D.C. 20004

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1415 G STREET, N.W.  
WASHINGTON, D.C. 20004



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  | REG. NO. 19154  |  |
|---|--|--|--|--|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR  |  |  |  |  |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST: Leon MIDDLE: SMITH LAST: SMITH   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH<br>MONTH: 7 DAY: 25 YEAR: 82  |  | 2b. HOUR: 9:15 P.M.  |  |   |  |
| 3. SEX: M.  |  | 4. RACE: BLACK   |  | 5. DATE OF BIRTH<br>MONTH: 8 DAY: 25 YEAR: 41  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>41 YRS.  |  | IF UNDER 1 YR. MONTHS: DAYS: HOURS: MIN:                                 |  | 2c. DATE PRONOUNCED DEAD<br>MONTH: 7 DAY: 25 YEAR: 82 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGES MD.                                      |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>LANTHAM  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Doctors Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>X-RAY TECHNICTION              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>WASH. HOSP. CT.                     |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE: MD. 13b. COUNTY: PRINCE GEORGES 13c. CITY OR TOWN: BOWIE  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>4403 ROEBLING CT.                                 |  |   |  |
| 14. FATHER'S NAME<br>FIRST: SONNY MIDDLE: THOMPSON LAST:  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST: RUTH MIDDLE: SMITH LAST:                                     |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO   |  |  |  | 16b. SOCIAL SECURITY NO.<br>578-56-9131  |  | 17. INFORMANT<br>ADDRESS: 4403 ROEBLING CT. SYLVIA SMITH, WIFE, BOWIE MD, 20715                 |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>0119 IMMEDIATE CAUSE (a) Cardiorespiratory arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } advanced tuberculosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) }<br>(c) }  |  |  |  |  |  |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE: SAUND A. DAER MD  |  |  |  | TITLE (SPECIFY): Deputy  |  |   |  | DATE SIGNED: 7-26-82   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT):  |  |  |  | ADDRESS:   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL   |  |  |  | 23b. DATE: 7/28/82   |  | 23c. NAME OF CEMETERY OR CREMATORY: LINCOLN MEMORIAL PARK                                       |  | 23d. LOCATION: SUTTLAND PG. MD.  |  |   |  |
| 24. FUNERAL DIRECTOR NAME: R&R FUNERAL SERVICES   |  |  |  | ADDRESS: 3520 CONN. AVE., WASHINGTON, D.C.   |  | RECEIVED BY REGISTRAR: JUL 30 1982  |  | REGISTRAR: [Signature]   |  |   |  |

## HOTMILK

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

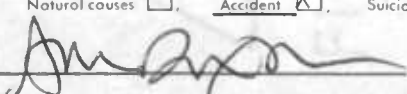

BP

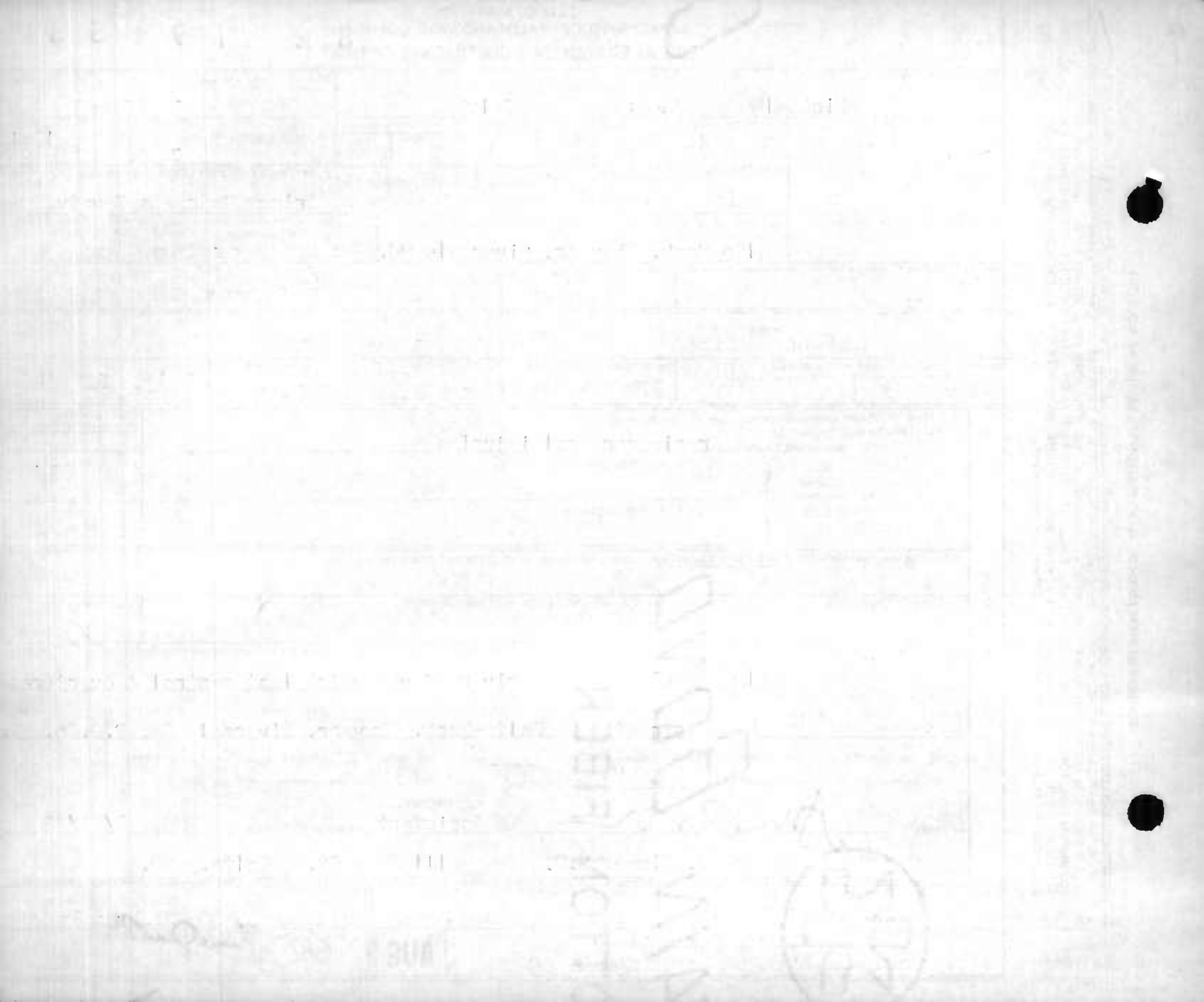
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                  |  |  |   |  |  |   |                        |  |
|--|------------------|--|--|---|--|--|---|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Michael David Smith   |                  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>7 20 1982                      |   |  | 2b. DATE OF DEATH<br>7 20 1982   |   |                        |  |
| 1. SEX<br>Male   | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 20, 1957  | 8. AGE (IN YEARS)<br>LAST BIRTHDAY<br>25 YRS.                          | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   | IF UNDER 24 HRS.<br>HOURS MIN  | 2c. DATE PRONOUNCED DEAD<br>7 20 1982                                    |   |                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, DC  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince George's County, MD       |   |                        |  |
| 10. CITY OR TOWN OF DEATH  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Balto-Wash. Pkwy nr. Riverdale Rd. |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Vender Operator |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>None   |                        |  |
| 13a. STATE<br>D.C.   |                  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Washington  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Raymond Alfonso Smith  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma Jean Bates       |   |  |  |   |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes/Navy  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>578-80-3261 |   | 17. INFORMANT<br>325 P Street, S.W.; Apt. 911<br>Emma J. Smith (mother) Wash. DC |  |   |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>8160 IMMEDIATE CAUSE (a) Cranio cerebral injuries<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |                  |  |  |   |  |  |   |                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                  |  |  |   |  |  |   |                        |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |                        |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>10:29xx 7 20 19 82  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10 PART I OR PART 2)<br>Driver of van which lost control & overturned                              |  |  |   |                        |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street  |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto-Wash. Pkwy nr. Riverdale Rd. P.G.Co., MD  |  |  |   |                        |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |  |   |  |  |   |                        |  |
| ACTUAL SIGNATURE<br>  |                  | TITLE (SPECIFY)<br>M.D. Assistant  |  |   | MEDICAL EXAMINER   |  |   | DATE SIGNED<br>7/21/82 |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |                  | ADDRESS<br>111 Penn St. Balto., MD.  |  |   |  |  |   |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  | 23b. DATE<br>7/24/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Washington National   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland P.G. CO. Maryland |   |                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>LATNEY's Funeral Home  |                  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 3 1982   |  |  |   |                        |  |
| 3831 Georgia Ave. NW; Washington, DC   |                  |  |  | 25b. REGISTRAR'S SIGNATURE<br>   |  |  |   |                        |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |   |                  |  |   |   |   |   |  |
|--|---|------------------|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   |                  | 2a. DATE KNOWN OF DEATH  |   |   | 2b. HOUR                                  |   |  |
| ROBIN L. SMITH   |   |                  | 7 31 19 82   |   |   | 4p M                                      |   |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH | 6. AGE (IN YEARS)  | IF UNDER 1 YR.  | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD                  |   |  |
| Female   | White   | 8/9/1957         | 24 YRS.  |   |   | 7 31 19 82 4p M                           |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH      |   |  |
| Maryland   | U.S.A.  |                  |  |   |   | Prince George's County MD                 |   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Brentwood  | 3661-Tilden-St.   |                  |  | 3601-Tilden St.   |   |   | Cashier   |  |
| 13a. STATE   |   |                  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS                       |   |  |
| Md.  |   |                  | Pr.Geo.  | Brentwood   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           | 3601-Tilden St.                           |   |  |
| 14. FATHER'S NAME  |   |                  | 15. MOTHER'S MAIDEN NAME   |   |   |   |   |  |
| William H. Smith Jr.   |   |                  | Mildred R. Robinson  |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |   |                  | 16b. SOCIAL SECURITY NO.   |   |   | 17. INFORMANT ADDRESS                     |   |  |
| No   |   |                  | 220-74-3672  |   |   | William H. Smith (above address) (Father) |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hanging</u><br>9530<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |   |                  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |   |                  |  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |   | 20. AUTOPSY?  |  |
|  |   |                  |  |   |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |   |                  | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |   |   |  |
|  |   |                  | ? P.M. 7-31- 1982  |   | Subject hanged self.  |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |   |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION   |   |   |  |
|  |   |                  | home   |   | 3661 Tilden St., Brentwood, Prince George's Md                                |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |   |                  |  |   |   |   |   |  |
| ACTUAL SIGNATURE   |   |                  | TITLE (SPECIFY)  |   |   |   | DATE SIGNED   |  |
|  |   |                  | M.D. Assistant MEDICAL EXAMINER  |   |   |   | 8-1-82  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |   |                  | ADDRESS  |   |   |   |   |  |
| Ann M. Dixon, M.D.   |   |                  | 111 Penn St., Balto., Md. 21201  |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |   |                  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION   |  |
| Burial   |   |                  | 8/5/1982   |   | Ft. Lincoln Cem.  |   | Brentwood, Pr. Geo. Md.   |  |
| 24. FUNERAL DIRECTOR NAME  |   |                  | 25a. DATE RECORD FILED IN REGISTRAR'S SIGNATURE  |   |   |   |   |  |
| Nalley's F.H. Inc.   |   |                  | AUG 9 1982   |   |   |   |   |  |

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF STAFF

7 21 10 101

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UNITED STATES DEPARTMENT OF THE ARMY

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UNITED STATES DEPARTMENT OF THE ARMY



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR OFFICIAL USE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |   |   |   |   |   |   | REG. NO. 19157  |  |
|---|--|-------------------------|--|---|---|---|---|---|---|---|--|
| 1- STATE REGISTRAR  |  |                         |  |   |   |   |   |   |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FOSTER F. SMOYER</b>   |  |                         |  |   |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>7-28 1982</b>   |   | 2b. HOUR<br><b>M</b>  |   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b> |  | 5. DATE OF BIRTH<br>(MONTH DAY YEAR) <b>May 6, 1924</b>     |   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>58</b> YRS.   |   | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN                                    |   | 7c. DATE PRONOUNCED DEAD<br><b>7-28 1982</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges</b> MD. |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hyattsville</b>   |  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2413 Chapman Road</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Model Maker</b>             |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov't.-Navy</b>                        |  |
| 13a. STATE<br><b>Maryland</b>   |  |                         | 13b. COUNTY<br><b>Prince Geo.</b>  |   | 13c. CITY OR TOWN<br><b>Hyattsville</b>                               |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>2413 Chapman Road</b>                   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert R. Smoyer</b>   |  |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carrie Crouse</b> |   |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes-Army W.W. II</b>  |  |                         | 16b. SOCIAL SECURITY NO.<br><b>199-12-0036</b>   |   | 17. INFORMANT<br><b>Curtis K. Smoyer</b>                              |   |   | ADDRESS <b>22 Lafko Dr. Poughkeepsie, N.Y.</b>                                |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4292 Atherosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                 |  |                         |  |   |   |   |   |   |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                         |  |   |   |   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |   |   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |                         |  |   |   |   |   |   |   |   |  |
| ACTUAL SIGNATURE <b>August P. Rodriguez</b>   |  |                         |  | TITLE (SPECIFY) <b>Deputy</b>                               |   |   |   | DATE SIGNED <b>7-28-82</b>  |   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>AUGUST P. RODRIGUEZ MD</b>   |  |                         |  | ADDRESS <b>5009 Rayburn Rd, Temple Hills, Md 20748</b>      |   |   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |                         | 23b. DATE<br><b>8-1-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mountain Grove Cem.</b>      |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Blacks Creek Luzerne Pa.</b> |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>   |  |                         |  |   |   | 25a. DATE REC'D BY REGISTRAR<br><b>AUG 2 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>                          |   |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |   |   |  |  |   |  |                                |  |
|---|--|---|---|---|--|--|---|--|--------------------------------|--|
| 1. FOR STATE REGISTRAR  |  |   |   |   | 8 2 1 9 1 5 8  |  |   |  |                                |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |   |   |   | 2a. DATE OF DEATH  |  |   |  |                                |  |
| JOSEPH Sylvio SOUCY   |  |   |   |   | MONTH DAY YEAR<br>07-13-82   |  |   |  |                                |  |
| 3. SEX<br>Male  |  |   |   |   | 7b. HOUR<br>7:50 A.M.  |  |   |  |                                |  |
| 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 2, 1902   |   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                              |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New Hampshire  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGE'S MD.                          |   |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br>CHEVERLY   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PRINCE GEORGE'S GENERAL HOSPITAL |   |   | 12a. USUAL OCCUPATION<br>(17th REVISED 1978) (GIVE WORKING LEE)<br>Brick Mason   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction           |  |                                |  |
| 13a. STATE<br>Maryland  |  |   |   |   | 13b. CITY OR TOWN<br>Hyattsville   |  |   |  |                                |  |
| 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |   | 13d. STREET ADDRESS<br>3103 West Lanham Drive  |  |   |  |                                |  |
| 14. FATHER'S NAME<br>Andre  |  |   |   |   | 15. MOTHER'S MAIDEN NAME<br>Amelia Arseneault  |  |   |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NAME & UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |   |   |   | 16b. SOCIAL SECURITY NO.<br>096 09 7338A   |  |   |  |                                |  |
| 17. INFORMANT<br>Helen Szabo  |  |   |   |   | 316 Arbor Oaks Court<br>Millersville, Md.  |  |   |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4140 CARDIO PULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ARTERIOSCLEROTIC HEART DISEASE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) CONGESTIVE HEART FAILURE<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>PRE-PYLORIC BLEEDING PEPTIC ULCER |  |   |   |   |  |  |   |  |                                |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/29/82, 19, to 7/13/82, 19, that (I) (we) last saw the deceased alive on 7/12/82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |   |  |                                |  |
| 22b. SIGNATURE<br>Arvind Mehla  |  |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED   |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ARVIND MEHTA   |  |   |   |   | 22e. ADDRESS<br>3700 EAST-WEST HIGHWAY H100<br>HYATTSVILLE MD 20783  |  |   |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial   |  |   | 23b. DATE<br>7/16/82  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft. Lincoln Cemetery   |  | 23d. LOCATION<br>Brentwood, Prince Georges County, Maryland |  |                                |  |
| 24. FUNERAL DIRECTOR<br>Francis Gasch's Sons Funeral Home, P.A.<br>Hyattsville, Maryland  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 19 1982   |  |   |  |                                |  |

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Millsville, Md.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called or contacted.

10

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 9 1 5 9

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST: MAURICE F LAST: SPARSHOTT  |   |   | 2a. DATE OF DEATH<br>MONTH: JULY DAY: 26, YEAR: 1982  |  | 2b. HOUR<br>1:10 A.M.  |
| 3. SEX<br>Male   | 4. RACE<br>Caucasian  | 5. DATE OF BIRTH<br>MONTH: Dec. 6, YEAR: 1887   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>94 YRS.                                     | IF UNDER 1 YEAR<br>MONTHS: DAYS: IF UNDER 24 HRS.<br>HOURS: MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, DC  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGE'S MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br>CLINTON   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SOUTHERN MARYLAND HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Painter                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Govt.  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE: Maryland 13b. COUNTY: Br. George's 13c. CITY OR TOWN: Brandywine   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST: Unknown MIDDLE: LAST: Unknown  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST: Unknown MIDDLE: LAST: Unknown                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) Unknown   |   | 16b. SOCIAL SECURITY NO.<br>N/A 579-01-2356   |   | 17. INFORMANT<br>Post Office Box 62<br>Brandywine, Maryland                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Adenocarcinoma of lungs<br>DUE TO, OR AS A CONSEQUENCE OF (b) malignancy<br>DUE TO, OR AS A CONSEQUENCE OF (c) terminal cancer<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/22/82, 19 to 1/25/82, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br>DR. M. MOASSER   |   |   |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. M. MOASSER  |   |   |   | 22e. ADDRESS<br>16005 CRAIN HWY., BRANDYWINE, MD. 20740                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |   | 23b. DATE<br>July 27, 1982  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lee's Crematory                          |  |
| 23d. LOCATION<br>CITY OR TOWN<br>Washington, DC  |   | 23e. DATE REC'D. BY REGISTRAR<br>AUG - 5 1982   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lee Funeral Home, Inc.   |   | 25. REGISTRAR'S SIGNATURE<br>John J. Conner   |   |  |  |
| Old Alexander Ferry Road, Clinton, Maryland 20734  |   |   |   |  |  |

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Handwritten text, possibly a signature or date, located in the lower-center of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |   | 8 2 1 9 1 6 0  |   |
|---|--|---|---|--|---|
| 1. FOR STATE REGISTRAR  |  |   |   | REG. NO.   |   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Spratley, Bertha C</i>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>7-4-82</i>                                 |  | 2b. HOUR<br><i>12:00 PM</i>   |
| 3. SEX<br><i>F</i>  | 4. RACE<br><i>N</i>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>Sept. 21, 1918</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>63</i>                                     | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Virginia</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>P.G.</i> MD.                          |   |
| 10. CITY OR TOWN OF DEATH<br><i>Clinton</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Clinton Comm Hosp</i> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><i>Virginia</i>   | 13b. COUNTY<br><i>Hampton</i>  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13. STREET ADDRESS<br><i>737 Childs Street</i>                                   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Orlando Dabney</i>  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Maria Crawley</i>                |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>no</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>228 14 6328</i>  |   | 17. INFORMANT ADDRESS<br><i>Yvonne Lynch-daughter-754 University Dr. Newport</i> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><i>1830</i> IMMEDIATE CAUSE (a) <i>metastatic ovarian carcinoma</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>19</i>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7-2-1982</i> , to <i>7-4-1982</i> , that (I) (we) last saw the deceased alive on <i>7-3-1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |   |  |   |
| 22b. SIGNATURE<br><i>Manohar Gulati M.D.</i>  |  |   | DEGREE<br><i>M.D.</i>   |  | 22c. DATE SIGNED<br><i>7/4/82</i>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>MANOHAR GULATI M.D.</i>   |  |   | 22e. ADDRESS<br><i>8901 Woodyard Rd. Clinton, Md.</i>                             |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>July 9, 1982</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Pleasant Shade Cemetery</i>             |   |
| 23d. LOCATION CITY OR TOWN<br><i>Hampton</i>  |  | COUNTY<br><i>Stafford</i>   |   | STATE<br><i>Virginia</i>   |   |
| 24. FUNERAL DIRECTOR NAME<br><i>John Stewart</i>  |  |   | 24b. ADDRESS<br><i>Stewart Funeral Home-4001 Benning Road</i>                     |  |   |
| 24c. DATE REC'D BY REGISTRAR<br><i>JUL 12 1982</i>  |  |   | 24d. SIGNATURE<br><i>John Stewart</i>   |  |   |



227, 228 • JGIM

6. *Conclusions*

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727 01174 12000

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and

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OH



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS ANTICIPATED. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |  |  |  |  |  |  |  | REG. NO. 19161  |  |
|--|--|----------------------|--|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR 8/31/82 rc  |  |                      |  |  |  |  |  |  |  | 20. DATE KNOWN OF DEATH   |  |
| 1 DECEASED NAME (TYPE OR PRINT) <b>RONALD W. STATZER</b>   |  |                      |  |  |  |  |  |  |  | 20. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>6</b> DAY <b>27</b> YEAR <b>1982</b> |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b> |  | 5. DATE OF BIRTH MONTH <b>11</b> DAY <b>16</b> YEAR <b>40</b>  |  | 6. AGE (IN YEARS) LAST BIRTHDAY <b>41</b> YRS.   |  | IF UNDER 24 HRS. MONTHS <b>1</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>   |  | 21. DATE PRONOUNCED DEAD MONTH <b>6</b> DAY <b>27</b> YEAR <b>1982</b>                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  | 8. <del>MARRIED</del> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD</b>                                     |  |
| 10. CITY OR TOWN OF DEATH <b>Largo</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Woods</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BROADCASTER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>TELEVISION</b>   |  |
| 13a. STATE <b>VIRGINIA</b>   |  |                      |  | 13b. CITY OR TOWN <b>FAIRFAX</b>   |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS <b>8360 GREENSBORO DRIVE</b>   |  |   |  |
| 14. FATHER'S NAME FIRST <b>WOODROW</b> MIDDLE <b>Woodie</b> LAST <b>STATZER</b>  |  |                      |  | 15. MOTHER'S MAIDEN NAME FIRST <b>MARIE</b> MIDDLE <b>Huff</b> LAST <b>Huff</b>                                      |  |  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>   |  |   |  |
| 16a. SOCIAL SECURITY NO. <b>224-54-7723</b>  |  |                      |  | 17. INFORMANT <b>MRS VALERIE STATZER</b>   |  |  |  | ADDRESS <b>7342 GRACELY DR. CINCINNATI, OHIO</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple injuries</b><br>8410<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                      |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                      |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10:20 AM 6-27-1982</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Pilot of motorized hang glider that crashed.</b>          |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>woods</b>   |  |  |  | 21f. LOCATION CITY OR TOWN <b>Largo</b> COUNTY <b>Prince George's Md</b> STATE <b>MD</b>   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                      |  |  |  |  |  |  |  | TITLE (SPECIFY) <b>Assistant</b>  |  |
| ACTUAL SIGNATURE <b>Ann M. Dixon</b>   |  |                      |  | M.D. <b>Assistant</b> MEDICAL EXAMINER   |  |  |  | DATE SIGNED <b>6-28-82</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |  |                      |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |                      |  | 23b. DATE <b>7-2-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>SPRING GROVE CEMETERY</b>                              |  |  |  | 23d. LOCATION CITY OR TOWN <b>CINCINNATI</b> COUNTY <b>HAMILTON</b> STATE <b>OHIO</b>                     |  |
| 24. FUNERAL DIRECTOR NAME <b>MARZULLO FUNERAL</b>  |  |                      |  | ADDRESS <b>REISTERSTOWN, MD</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JUL 1 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Frances Jan Warren</b>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |  |  |  |  | 8  | 2 | 1   | 9 | 1                                 | 6 | 2 |
|--|--|--|--|---|--|--|--|--|--|--|---|---|---|-----------------------------------|---|---|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |  |  |  |  | CERTIFICATE OF DEATH   |   |   |   |                                   |   |   |
| I. DECEASED NAME (TYPE OR PRINT)   |  |  |  |   |  |  |  |  |  | 2a. DATE OF DEATH  |   |   |   | 2b. HOUR                          |   |   |
| FRANCES A. STEPHENS  |  |  |  |   |  |  |  |  |  | 07-13-82   |   |   |   | 6:35AM                            |   |   |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |   |   |   |                                   |   |   |
| Female   |  | Black  |  | March 23, 1945  |  | 37   |  | MONTHS   |  | DAYS   |   | HOURS   |   | MIN                               |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |  |   |   |   |                                   |   |   |
| New York   |  | U.S.A.   |  |   |  | PRINCE GEORGE'S COUNTY MD.   |  |  |  |  |   |   |   |                                   |   |   |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  |  |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |   |
| CHEVERLY   |  | PRINCE GEORGE'S GENERAL HOSPITAL   |  |   |  |  |  |  |  |  |   | Waitress  |   | Restaurant                        |   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |  |  |  |  | 13a. INSIDE CITY LIMITS?                                       |   | 13c. STREET ADDRESS   |   |                                   |   |   |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 3120 75th. Ave. Apt-103  |  |  |   |   |   |                                   |   |   |
| Maryland   |  | P.G.   |  | Landover  |  |  |  |  |  |  |   |   |   |                                   |   |   |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |  |   |   |   |                                   |   |   |
| FIRST  |  | MIDDLE   |  | LAST  |  | FIRST  |  | MIDDLE   |  | LAST   |   |   |   |                                   |   |   |
| Russell  |  |  |  | Hall  |  | Ann  |  |  |  | Anderson   |   |   |   |                                   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |  |  |  |   |   |   |                                   |   |   |
| No   |  |  |  | 577-58-9922   |  | Mr. Charles M. Stephens No# 13c.   |  |  |  |  |   |   |   |                                   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |   |   |   |                                   |   |   |
| IMMEDIATE CAUSE (a) Respiratory Failure  |  |  |  |   |  |  |  |  |  | 3 weeks  |   |   |   |                                   |   |   |
| DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Breast Cancer  |  |  |  |   |  |  |  |  |  | 1 year   |   |   |   |                                   |   |   |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |  |  |  |  |  |   |   |   |                                   |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |   |  |  |  |  |  |  |   |   |   |                                   |   |   |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |   |   |                                   |   |   |
|  |  |  |  |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |   |   |                                   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |  |  |  |  |   |   |   |                                   |   |   |
|  |  |  |  | P.M. 19   |  |  |  |  |  |  |   |   |   |                                   |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |  |  |   |   |   |                                   |   |   |
|  |  |  |  |   |  |  |  |  |  |  |   |   |   |                                   |   |   |
| 22a. I certify that (b) (this hospital) attended the deceased from 15 April 1982 to 13 July 1982, that (we) lost saw the deceased alive on 12 July 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |  |   |   |   |                                   |   |   |
| 22b. SIGNATURE   |  |  |  | DEGREE  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |   |   |   |                                   |   |   |
| Thomas A. Bensinger  |  |  |  |   |  |  |  |  |  | 7/13/82  |   |   |   |                                   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS  |  |  |  |  |  |  |   |   |   |                                   |   |   |
| Thomas A. Bensinger  |  |  |  | 7676 New Hampshire Ave, Langley Park MD 20883   |  |  |  |  |  |  |   |   |   |                                   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |   |   |   |                                   |   |   |
| Burial   |  |  |  | 7-16-82   |  | Ft. Lincoln Cemetery   |  | Brentwood  |  | P.G. Maryland  |   |   |   |                                   |   |   |
| 24. FUNERAL DIRECTOR   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |   |   |   |                                   |   |   |
| F. Gasch's Sons F.H. P.A. Hyattsville, Md.   |  |  |  |   |  | JUL 16 1982  |  | Frances Jan Nathan   |  |  |   |   |   |                                   |   |   |

F. Masch's Sons P.O. Box 1, Yattaville, Md.

Burial 7-18-32 Ft. Lincoln Cemetery Brentwood P.D. Maryland

No

577-58-9922 Mr. Charles A. Stephens No. 129.

Address same as  
Anderson

Russell

Hall

Ann

Maryland

P.D.

Handover

x

5120 75th Ave. Apt-102

Chevrolet

PRINCE GEORGE'S HOSPITAL

Waters

Restaurant

New York

U.S.A.

x

PRINCE GEORGE'S COUNTY

Female

Black

March 27, 1945

37

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 2 1 9 1 6 3   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Margaret STEWART</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 20, 1982</b>   |  | 2b. HOUR<br><b>8:45p</b> M   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAR 13, 1913</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George's</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Lanham</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Doctors' Hospital of Pr. Geo. Co.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>  |  |
| 13a. STATE<br><b>MD</b>   |  |   |  | 13b. COUNTY<br><b>P.G.</b>  |  | 13c. CITY OR TOWN<br><b>Fairmount Hts</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Fletcher</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ella Contre</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>UNKNOWN</b>  |  | 17. INFORMANT ADDRESS<br><b>Louis Fletcher 4705 Church Rd Mt. Airy, N.C.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Renal insuff. failure.</b><br>2503<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Diabetic nephropathy.</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>Intestinal obstruction.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-16</b> , 19 <b>82</b> , to <b>7-20</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>7-20</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.    |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>7-20-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Cleo A Montanet MD</b>  |  |   |  | 22e. ADDRESS<br><b>3308 Dodge PK Rd Landover MD</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><b>7-24-1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Harmony Mem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Landover MD Prince Georges</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>H. S. Washington - Sr</b><br>ADDRESS<br><b>Bonhought Avenue</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 28 1982</b>   |  |  |  |

Handwritten header information, possibly a date and page number, located at the top of the page.

Main body of handwritten text, consisting of several lines of cursive script.

Handwritten text at the bottom of the page, including a signature and possibly a date.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after burial with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 2 1 9 1 6 4  |  |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH  |  |
| FIRST MIDDLE LAST<br>Annie Marie Sullivan  |  |  |  | MONTH DAY YEAR HOUR<br>7/14/82 2:10 PM   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 14, 1917   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Canada   |  | 8. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 9a. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince George's County MD.  |  | 10. CITY OR TOWN OF DEATH<br>Clinton   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Southern Maryland Hospital |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Meat Packer   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Briggs Meat   |  | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                      |  |
| 13b. COUNTY<br>Pr Geo  |  | 13c. CITY OR TOWN<br>Suitland  |  | 13d. STREET ADDRESS<br>3517 Terrace Drive  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Duffy  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Hazel Goldrich  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |
| 16b. SOCIAL SECURITY NO<br>--  |  | 16c. SOCIAL SECURITY NO<br>577 24 7847   |  | 17. INFORMANT ADDRESS<br>John L. Sullivan Same as #13  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Adenocarcinoma Lung</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>COLD</u>  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (the hospital) attended the deceased from <u>6-6</u> , 19 <u>82</u> , to <u>7-14</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>7-14</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><u>William Kent Durnst</u>   |  | DEGREE<br><u>MD</u>  |  | 22c. DATE SIGNED<br><u>7-15-82</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William Furst, M.D.   |  | 22e. ADDRESS<br>9401 Indian Head Hwy, Ft. Washington, Md.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>19 July 82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland PG Md   |  | 24. FUNERAL DIRECTOR<br>NAME Robert E. Wilhelm<br>Funeral Home Inc<br>ADDRESS Suitland, Md   |  |  |  |
| 25a. DATE REC'D BY REGISTRAR<br>JUL 21 1982  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Frank J. [Signature]</u>  |  |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |  |  |  | 8 2 1 9 1 6 5  |  |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Isabell M. Summers</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>July</b> DAY <b>3</b> YEAR <b>1982</b>  |  |   |  | 2b. HOUR <b>8:15AM</b>   |  |  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>April 20</b> DAY <b>1908</b> AR  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>74</b>  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                       |  | IF UNDER 74 HRS.<br>HOURS <b></b> MIN. <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George's County</b> MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Riverdale</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Leland Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(FIELD OF WORK OR MOST RECENT WORK) <b>National Bank</b><br>12b. <b>Bank Clerk, Ret.</b> INDUSTRY <b>of Washington</b> |  |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |   |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Prince Geo.</b>  |  | 13c. CITY OR TOWN<br><b>Hyattsville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>3601 Gallatin Street</b>                                   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Benjamin</b> MIDDLE <b></b> LAST <b>Gates</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Lillian</b> MIDDLE <b></b> LAST <b>Wedding</b>   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR NO OR UNKNOWN) <b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>577 05 1795D</b>   |  | 17. INFORMANT<br>ADDRESS <b>Same as #13 (Friend)</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF OVARY'S</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SECONDARY METASTASIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>RENAL FAILURE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>CORONARY ARTERY DISEASE</b>  |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN   |  | COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6.25</b> 19 <b>82</b> to <b>7.3</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>7.2</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>V.R. SINGH</b>   |  |  |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>V.R. SINGH</b>  |  |  |  | 22e. ADDRESS<br><b>6490 LANDOVER RD<br/>LANDOVER MD 20785</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>7/6/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Cemetery</b>  |  | 23d. LOCATION<br><b>Washington D.C.</b> COUNTY STATE                                 |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Francis Gasch's Sons Funeral Home, P.A.</b><br>Hyattsville, Maryland   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 7 1982</b>  |  |  |  |  |  |
|   |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Francis San Nathan</b>   |  |  |  |  |  |



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### Low Income

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and 1997). The authors of this paper have been involved in the development of the first two of these systems.

177 of 1780 Joseph W. Nicholls June 25 1870 (United)

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27. *Library & Computer*

## 2.2.1 not-in-use

Francis Joseph's Sons' Funeral Home,  
Westville, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |   |  |  |  |  |
|---|--|--|--|---|---|--|--|--|--|
| 1 - FOR STATE REGISTRAR   |  |  |  |   | 8 2 1 9 1 6 6<br>REG. NO.   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SEUNG H. SWAIN   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 17, 1982  |  |  | 2b. HOUR<br>1:00P M  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Oriental  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 20, 1930   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Korea  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince George's County, MD.                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Clinton  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Southern Maryland Hospital Center |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Medical Technician |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Medical   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Pr. George's 13c. CITY OR TOWN Temple Hills  |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>5703 Old Branch Avenue  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><del>Unknown</del> Kim Nabuge   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><del>Unknown</del> Jaw Schiewdang              |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A   |  | 17. INFORMANT<br>577-50-3422  |   | ADDRESS<br>Justin Swain - Same As 13 A-E   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>exhaustion/pulmonary failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic lung cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>1629 |  |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |
| 22a. I certify that (if this hospital) attended the deceased from <u>July 16</u> , 19 <u>82</u> , to <u>July 17</u> , 19 <u>82</u> , that (1) <u>he</u> lost <u>saw the deceased alive on</u> <u>above</u> , (2) <u>we</u> <u>did not</u> view the body after death.  |  |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>  |  |  |  |   | DEGREE<br>ND  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>7/18/82                  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>NAIDAR</u>  |  |  |  |   | 22e. ADDRESS<br><u>Hagerstown Md</u>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>July 20, 1982   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery                                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland Pr. George's MD   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME Lee Funeral Home, Inc.<br>ADDRESS  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>JUL 21 1982 <u>[Signature]</u>      |  |  |  |  |

... ..

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VRA 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |  |
| FIRST MIDDLE LAST  |  | MONTH DAY YEAR HOUR  |  |
| Roy K Swann  |  | 07 26 82 2:40 <sup>A</sup>   |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                |
| Male   | White  | MONTH DAY YEAR   | IF UNDER 1 YEAR IF UNDER 24 HRS                                |
|  |  | Oct. 5, 1899   | 82 YRS. MONTHS DAYS HOURS MIN                                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |
| Maryland   | U.S.A.   |  | Prince Georges MD.   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                              |
| Suitland   | Southern Md. Hospital Center   | Mechanic-Ret.  | Gas Station  |
| 13a. STATE   |  | 13b. COUNTY  | 13c. CITY OR TOWN  |
| Maryland   | Prin. Geo. Camp Sprs.  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  |
| George G Swann   |  | Effie Rice   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  |
| No   |  | 578-10-8375  |  |
| 17. INFORMANT  |  | ADDRESS  |  |
| Robert Swann   |  | Rt. 1 Box 89B Nanjemoy, Maryland   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| IMMEDIATE CAUSE (a) <u>STROKE</u>  |  |  | 1 WEEK   |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIAL INSUFFICIENCY</u>   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)   |  |  |  |
| <u>ABDOMINAL PAIN</u>  |  |  |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
|  | P.M. 19  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
|  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>7/24</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   | 22c. DATE SIGNED   |
| <u>PW</u>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               | <u>7/26/82</u>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |
| Philip Wisotsky, M.D.  |  | 6188 Oxon Hill Rd. Oxon Hill, Md.  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |
| Burial   | 07/28/82   | Cedar Hill   | Suitland Prince Georges Md.                                    |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR  |  |
| Arehart Funeral Homes, Inc   |  | JUL 29 1982  |  |
| ADDRESS  |  | SIGNATURE  |  |
| La Plata, Md.  |  | <u>B.G. [Signature]</u>  |  |

1204 BP





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO. 2 1 9 1 6 8   |  |   |  |
|---|--|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>William H. Switzer</b>  |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <b>7 3 82</b>  |  |   |  |
| 3. SEX <b>Male</b> 4. RACE <b>White</b> 5. DATE OF BIRTH <b>April 10 08</b> 6. AGE (IN YEARS) <b>74</b> 7. IF UNDER 1 YR. <b>MONTHS</b> <b>DAYS</b> <b>HOURS</b> <b>MIN.</b> 8. IF UNDER 24 HRS. <b>MONTHS</b> <b>DAYS</b> <b>HOURS</b> <b>MIN.</b>   |  |  |  |  |  |  |  |  |  | 2b. HOUR <b>8:22</b> 2c. DATE PRONOUNCED DEAD <b>7 3 82</b> 2d. HOUR <b>8:22</b>   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indiana</b> 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George County</b> MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Laurel</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Laurel Hospital</b>  |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b> |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>P.G. Co.</b> 13c. CITY OR TOWN <b>Laurel</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>305 9 th St. Apt. # 2 Laurel Md</b>  |  |  |  |  |  |  |  |  |  |  |  |   |  |
| 14. FATHER'S NAME <b>Doran</b> 15. MOTHER'S MAIDEN NAME <b>Ida Montgomery</b>   |  |  |  |  |  |  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WWI</b> 16b. SOCIAL SECURITY NO. <b>372-10-7872</b> 17. INFORMANT <b>Carol Lanham RTE I Box 92 a Crownsville Md</b>  |  |  |  |  |  |  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4292 Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>ASU</b><br>(b) <b>ASU</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>SAN A DARRIN</b> TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER   |  |  |  |  |  |  |  |  |  | DATE SIGNED <b>7-4-82</b>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |  |  |  |  |  |  |  |  | ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>July 7, 1982</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Cemetery</b> 23d. LOCATION CITY OR TOWN <b>Odenton</b> COUNTY <b>Annapolis</b> STATE <b>Md</b>   |  |  |  |  |  |  |  |  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>T.A. Hardesty</b> ADDRESS <b>Annapolis, Maryland 21401</b> 25a. DATE REC'D. BY REGISTRAR <b>JUL 6 1982</b> REGISTRAR <b>James J. Hardesty</b>  |  |  |  |  |  |  |  |  |  |  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |  |   |  |                                  |   |
|---|--|---|--|--|--|---|--|----------------------------------|---|
| FOR<br>1- STATE<br>REGISTRAR  |  |   |  |  | 8 2 1 9 1 6 9<br>CERTIFICATE OF DEATH  |   |  |                                  |   |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  |  | 2a DATE OF DEATH MONTH DAY YEAR  |   |  |                                  |   |
| MARY E TABBS  |  |   |  |  | 07-20-82   |   |  |                                  |   |
| 3 SEX   |  | 4 RACE  |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                  |  | 7b HOUR                          |   |
| Female  |  | Black   |  | May 6, 1906  |  | 76 YRS  |  | 12 P M                           |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                             |  |                                  |   |
| VA  |  | U.S.A.  |  |  |  | PRINCE GEORGE'S MD.   |  |                                  |   |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b KIND OF BUSINESS OR INDUSTRY |   |
| CHEVERLY  |  | PRINCE GEORGE'S GENERAL HOSPITAL  |  |  |  | Housewife   |  | Home                             |   |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  | 13d INSIDE CITY LIMITS?  |   |  |                                  |   |
| 13b STATE   |  |   |  |  | 13c CITY OR TOWN   |   |  |                                  |   |
| MD  |  |   |  |  | Lanham   |   |  |                                  |   |
| 14. FATHER'S NAME   |  |   |  |  | 15. MOTHER'S MAIDEN NAME   |   |  |                                  |   |
| First MIDDLE LAST   |  |   |  |  | First MIDDLE LAST  |   |  |                                  |   |
| Unknown   |  |   |  |  | Unknown  |   |  |                                  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  |  | 16b. SOCIAL SECURITY NO.   |   |  |                                  |   |
| NO  |  |   |  |  | UNKNOWN  |   |  |                                  |   |
| 17 INFORMANT  |  |   |  |  | ADDRESS  |   |  |                                  |   |
| Robert Williams   |  |   |  |  | SAME AS #13 ABOVE  |   |  |                                  |   |
| 18 CAUSE OF DEATH (Enter only one cause per part for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4140 IMMEDIATE CAUSE (a) Cerebral Vascular Accident<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) Congestive Heart Failure<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) Arteriosclerotic Heart Disease<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Hypertension |  |   |  |  |  |   |  |                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>30 d<br>3 yrs<br>10 yrs |
| 19a DATE OF OPERATION   |  |   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                               |   |  |                                  |   |
|   |  |   |  |  |  |   |  |                                  |   |
| 20a AUTOPSY?  |  |   |  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                  |   |  |                                  |   |
| YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |  |                                  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                     |   |  |                                  |   |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |                                  |   |
| 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   |  |  | 21i LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |   |  |                                  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 20 to 7/20 19 82 that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  | 22c. DATE SIGNED<br>7/21/82  |   |  |                                  |   |
| 22b. SIGNATURE<br>Dr. Henry A. Wise Jr.   |  |   |  |  | 22e ADDRESS<br>Lanham, MD  |   |  |                                  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Henry A. Wise Jr.  |  |   |  |  | 22f. ADDRESS<br>Lanham, MD   |   |  |                                  |   |
| 23a BURIAL CREMATION REMOVAL  |  |   |  |  | 23b. DATE  |   |  |                                  |   |
| 23c. NAME OF CEMETERY OR CREMATORY  |  |   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                     |   |  |                                  |   |
| HARMONY MEM. PARK   |  |   |  |  | HIGHLAND PARK  |   |  |                                  |   |
| 24 FUNERAL DIRECTOR<br>NAME<br>H. S. WASHINGTON & SONS 4925 BURROUGHS AVE. N.E.   |  |   |  |  | 25a DATE RECEIVED BY REGISTRAR<br>JUL 28 1982                                  |   |  |                                  |   |

TABLE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | 8 2 1 9 1 7 0<br>REG. NO.                              |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | I. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Janice Lou Tackett</b>   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>July 1, 1982</b>  |  | 2b. HOUR<br><b>4:30 PM</b>                             |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Feb. 12, 1940</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>42</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George, Co. MD.</b>                           |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Laurel</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Laurel Beltsville Hosp.</b> |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Waitress</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Restaurant</b> |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>P.G. Co.</b>   |  | 13c. CITY OR TOWN<br><b>Laurel</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>605 Park Ave.</b>  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William H. Ewing</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Euphia L. Moss</b>   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No.</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>235-60-9671</b>  |  | 17. INFORMANT ADDRESS<br><b>James A. Tackett same as #13</b>                                    |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b><br>4310<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>massive intracerebral hemorrhage</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>6-30-</b> 19 <b>82</b> to <b>7-1-</b> 19 <b>82</b> , that (1) (we) lost saw the deceased alive on <b>7-1-</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)                           |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>G. A. De La Torre</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br><b>7-1-82</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G. A. DE LA TORRE</b>  |  |  |  | 22e. ADDRESS<br><b>320 Montgomery St. Laurel, Md. 20707</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7/3/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Park</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Howard, Md.</b>                        |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>FLECK LAUREL FUNERAL HOME, INC.</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 6 1982</b>  |  |  |  |  |  |
| 24b. ADDRESS<br><b>7601 Sandy Spring Rd. Laurel, Md. 20707</b>   |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Carroll</b>  |  |  |  |  |  |

1911-12

1912-13

1913-14

1914-15

1915-16

1916-17

1917-18

1918-19

1919-20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 7 2 1 9 1 7 1   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Ervin A. Tappan</b>  |  |   |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>7-26-82</b>   |  | 2b HOUR<br><b>3:45am</b>   |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>Oct 1, 1891</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN.<br><b>90</b>   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Hampshire</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George County MD.</b>   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Clinton</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Southern Maryland Hospital</b> |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engineer</b>   |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Public Housing</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Maryland</b>   |  |   |  | 13b COUNTY<br><b>PG</b>   |  | 13c CITY OR TOWN<br><b>Suitland</b>  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Samuel Tappan</b>  |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Emma Smith</b>  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b SOCIAL SECURITY NO.<br><b>578 58 8200</b>   |  | 17 INFORMANT<br><b>June Stocklinski</b>   |  | ADDRESS<br><b>Rt#3 Box 433 Front Royal, Va.</b>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b><br><b>4275</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |   |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>7-4</b> 19 <b>82</b> , to <b>7-25</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>7-25</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.            |  |   |  |   |  |  |  |
| 22b SIGNATURE<br><b>Cyrus Dondygar M.D.</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |  | 22c DATE SIGNED<br><b>7-26-82</b>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CYRUS DONDYGAR</b>   |  |   |  | 22e ADDRESS<br><b>6188 OKON HILL RD, OKONHILL, MD.</b>  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b DATE<br><b>31 July 82</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Woodstock Cemetery</b>  |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br><b>Woodstock New Hampshire</b>   |  |
| 24 FUNERAL DIRECTOR NAME<br><b>Robert E. Wilhelm</b>  |  |   |  | ADDRESS<br><b>Frrl Home Suitland, Md.</b>   |  | 25a DATE REC'D. BY REGISTRAR<br><b>JUL 30 1982</b>   |  |



INVT-20



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UNITED STATES

1-32 1-32 1-32 1-32 1-32

1-32-82 1-32-82 1-32-82 1-32-82 1-32-82

JUL 1 1982

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |   |  |                               |   |  |
|---|--|---|--|--|---|--|-------------------------------|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  |   |  |                               |   |  |
| CERTIFICATE OF DEATH  |  |   |  |  |   |  |                               |   |  |
| REG. NO.  |  |   |  |  |   |  |                               |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>CATHERINE Rose TAYLOR</b>  |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br><b>July 25 821:51<sup>AM</sup></b> |  |                               |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Dec. 29, 1917</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>64</b>                     |                               | 7. IF UNDER 1 YEAR IF UNDER 24 HRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington DC</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>PR. GEO.</b> MD.                                  |                               |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>CLINTON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>56. md. Hosp. Ctr.</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dye Stamper</b>          |                               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Woodward and Lothrop</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  |   |  |                               |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>PG</b>  |  | 13c. CITY OR TOWN<br><b>Forestville</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                               | 13e. STREET ADDRESS<br><b>7704 Mane Lane Street</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Nicholas Loreto</b>   |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Borrello</b>              |  |                               |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>578 18 9052</b>  |  | 17. INFORMANT<br><b>William J. Taylor</b>  |   |  | ADDRESS<br><b>Same as #13</b> |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |  |   |  |                               |   |  |
| PART I. DEATH WAS CAUSED BY:  |  |   |  |  |   |  |                               |   |  |
| IMMEDIATE CAUSE (a) <b>SEPSIS</b>   |  |   |  |  |   |  |                               |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>CELLULITIS (L) FOOT &amp; ANKLE</b>   |  |   |  |  |   |  |                               |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>UNCONTROLLED MALIGNANT LYMPHOMA</b>   |  |   |  |  |   |  |                               |   |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 DAYS</b><br><b>2 WKS</b><br><b>15 mos</b>  |  |   |  |  |   |  |                               |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |  |   |  |                               |   |  |
| MEDICAL CERTIFICATION   |  |   |  |  |   |  |                               |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |                               |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |                               |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>APRIL 81</b> , to <b>JULY 21 1982</b> , that (I) (we) last saw the deceased alive on <b>JULY 24 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. |  |   |  |  |   |  |                               |   |  |
| 22b. SIGNATURE<br><b>James G. Brown</b>   |  | 22c. DATE SIGNED<br><b>7/25/82</b>  |  |  |   |  |                               | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES A. BROWN, MD</b>  |  |
| 22e. ADDRESS<br><b>6125 BELCREST RD<br/>AYATTSVILLE, MD 20782</b>   |  | 22f. DATE SIGNED BY REGISTRAR<br><b>JUL 30 1982</b>   |  |  |   |  |                               |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>28 July 82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Veterans Cem</b>  |   | 23d. LOCATION CITY OR TOWN COUNTY<br><b>Cheltenham PG</b>                                    |                               | 23e. STATE<br><b>MD</b>   |  |
| 24. FUNERAL DIRECTOR'S NAME<br><b>Robert E. Wilhelm</b>   |  |   |  |  |   |  |                               |   |  |
| ADDRESS<br><b>Fnr1 Home Suitland, MD</b>  |  |   |  |  |   |  |                               |   |  |

8

7

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

WASHINGTON, D. C.

REPORT OF THE  
COMMISSIONER OF PLANT INDUSTRY  
FOR THE YEAR 1907

CONTENTS

|                                     |    |
|-------------------------------------|----|
| Introduction                        | 1  |
| General Statistics                  | 10 |
| Production of Plant Products        | 15 |
| Consumption of Plant Products       | 20 |
| Export and Import of Plant Products | 25 |
| Plant Industry in the United States | 30 |
| Plant Industry in Foreign Countries | 35 |
| Plant Industry in the World         | 40 |

APPENDIX

|                                     |    |
|-------------------------------------|----|
| Plant Products of the United States | 45 |
| Plant Products of Foreign Countries | 50 |
| Plant Products of the World         | 55 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. These permits are removed from the certificate. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |                          |   |  |  |  | 8 2 1 9 1 7 3                                   |  |            |  |  |
|---|--|---|--|--|--------------------------|---|--|--|--|---|--|------------|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  |  | CERTIFICATE OF DEATH     |   |  |  |  |   |  |            |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |  | 2a. DATE OF DEATH        |   |  |  |  | 2b. HOUR  |  |            |  |  |
| MINNIE V. TAYLOR  |  |   |  |  | 07-18-82                 |   |  |  |  | 2:20PM  |  |            |  |  |
| 3 SEX   |  | 4 RACE  |  | 5 DATE OF BIRTH  |                          | 6 AGE   |  | 7 IF UNDER 1 YEAR  |  | 8 IF UNDER 74 HRS.                              |  |            |  |  |
| Female  |  | Cauc.   |  | Jan. 12 1907   |                          | 75  |  | MONTHS   |  | DAYS  |  | HOURS MIN. |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |  |  |   |  |            |  |  |
| Washington, D.C.  |  | U.S.A.  |  |  |                          | PRINCE GEORGE'S MD.   |  |  |  |   |  |            |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |   |  |            |  |  |
| CHEVERLY  |  | PRINCE GEORGE'S GENERAL HOSPITAL  |  |  |                          | Housewife   |  |  |  |   |  |            |  |  |
| 13a. STATE  |  | 13b. CITY OR TOWN   |  | 13c. INSIDE CITY LIMITS?   |                          | 13d. STREET ADDRESS   |  |  |  |   |  |            |  |  |
| Maryland  |  | North Beach   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                          | P.O. Box 385  |  |  |  |   |  |            |  |  |
| 14. FATHER'S NAME   |  |   |  |  | 15. MOTHER'S MAIDEN NAME |   |  |  |  |   |  |            |  |  |
| John Myers  |  |   |  |  | Florence Brown           |   |  |  |  |   |  |            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |                          | ADDRESS   |  |  |  |   |  |            |  |  |
| No  |  | 578-03-9883   |  | Clyde M. Taylor  |                          | P.O. Box 385 North Beach, Md. 20741                                 |  |  |  |   |  |            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |  |   |  |  |                          |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |            |  |  |
| 4100 IMMEDIATE CAUSE (a) Myocardial Infarction, Acute   |  |   |  |  |                          |   |  |  |  | 24 hours  |  |            |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |   |  |  |                          |   |  |  |  |   |  |            |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |   |  |  |                          |   |  |  |  |   |  |            |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |  |                          |   |  |  |  |   |  |            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a  |  |   |  |  |                          |   |  |  |  |   |  |            |  |  |
| Acute Hydrocephalus 2nd to Cerebral Hemorrhage  |  |   |  |  |                          |   |  |  |  |   |  |            |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |                          | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |   |  |            |  |  |
| 2/5/82  |  | Hydrocephalus   |  |  |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |   |  |            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |                          |   |  |  |  |   |  |            |  |  |
|   |  | P.M. 19   |  |  |                          |   |  |  |  |   |  |            |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET  |                          | CITY OR TOWN  |  | COUNTY   |  | STATE   |  |            |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY  |  | 21f. LOCATION  |                          | CITY OR TOWN  |  | COUNTY   |  | STATE   |  |            |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY  |  | 21f. LOCATION  |                          | CITY OR TOWN  |  | COUNTY   |  | STATE   |  |            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/12/82, 19, to 7/11/82, 19, that (I) (we) lost saw the deceased alive on 2/17, 19, 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |                          |   |  |  |  |   |  |            |  |  |
| 22b. SIGNATURE  |  | DEGREE  |  | 22c. DATE SIGNED   |                          |   |  |  |  |   |  |            |  |  |
| Joel L. Falik   |  | M.D.  |  | July 21, 82  |                          |   |  |  |  |   |  |            |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  | 22f. DATE SIGNED   |                          |   |  |  |  |   |  |            |  |  |
| Joel L. Falik M.D.  |  | 6005 Landover Rd Cheverly Md  |  | July 21, 82  |                          |   |  |  |  |   |  |            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |                          | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY   |  | STATE   |  |            |  |  |
| Removal   |  | 7/20/1982   |  | Georgetown Med. School   |                          | Washington, D.C.  |  | COUNTY   |  | STATE   |  |            |  |  |
| 24. FUNERAL DIRECTOR  |  |   |  |  |                          | 25. DATE REC'D. BY REGISTRAR  |  |  |  |   |  |            |  |  |
| Columbia Mortuary Services, Inc.  |  |   |  |  |                          | JUL 26 1982   |  |  |  |   |  |            |  |  |
| 225 Missouri Ave. NW Washington, D.C.   |  |   |  |  |                          |   |  |  |  |   |  |            |  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |   |  |   | 8 2 1 9 1 7 4   |   |
|---|---|--|---|---|---|
| 1. FOR STATE REGISTRAR  |   | CERTIFICATE OF DEATH   |   | REG. NO.  |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Muriel F. Taylor</b>   |   | 2a. DATE OF DEATH<br><b>July 20, 1982</b>  |   | 2b. HOUR<br><b>9:00PM</b>   |   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br><b>Nov. 28, 1922</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D.C.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George's</b> MD.                              |   |
| 10. CITY OR TOWN OF DEATH<br><b>Riverdale</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Leland Memorial Hospital</b> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Technician</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov't.</b>   |   |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY<br><b>P.G.</b>   | 13c. CITY OR TOWN<br><b>University Park</b> | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 13e. STREET ADDRESS<br><b>4403 Tuckerman Street</b> |
| 14. FATHER'S NAME<br><b>Asa Brockman</b>  |   | 15. MOTHER'S MAIDEN NAME<br><b>Alice Payne</b>   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>W.W.11&amp;Korea 578-38-6362</b>  |   | 17. INFORMANT ADDRESS<br><b>Address Same as No# 13e.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Breast carcinoma</b><br>1749<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |   |  |   |   |   |
| 19a. DATE OF OPERATION<br><b>7/18/82</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>19</b>  |   | 20a. AUTOPSY?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO            |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>21b. TIME OF INJURY</b> HOUR A.M. MONTH DAY YEAR<br><b>21c. HOW INJURY OCCURRED</b> (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>21d. INJURY OCCURRED</b> WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK<br><b>21e. PLACE OF INJURY</b> (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>21f. LOCATION</b> STREET CITY OR TOWN COUNTY STATE<br><b>21g. I certify that (I) (this hospital) attended the deceased from 7/18/82 to 7/20/82, that (I) (we) last saw the deceased alive on 7/20/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b><br><b>21h. SIGNATURE</b> <b>DEGREE</b><br><b>21i. PHYSICIAN'S NAME</b> (TYPE OR PRINT)<br><b>Abraham Dabela, M.D.</b><br><b>21j. ADDRESS</b><br><b>4404 Queensbury Rd., Riverdale, Md. 20737</b> |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 22b. DATE<br><b>July 23, 1982</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Chestnut Grove Cem.</b>                                |   |
| 22d. LOCATION<br>CITY OR TOWN<br><b>Herndon</b>   |   | COUNTY<br><b>Fairfax</b>   |   | STATE<br><b>Virginia</b>  |   |
| 23. FUNERAL DIRECTOR<br><b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>   |   | 24. DATE REC'D. BY REGISTRAR<br><b>JUL 23 1982</b>   |   |   |   |

7. Canale born 7.11.1944, Hyattsville, Md.  
 July 27, 1982 Chestnut Grove Cem. Herndon Fairfax Virginia

x

Yes N.Y. Licenses 878-28-8202 Miss Louise T. Taylor  
 Address same as Payne Alice Brochman

Maryland P.D. University Park x 4802 Tuckerman Street

Ret. Technician U.S. Gov't.

Washington, D.C. U.S.A. x

Female White Nov. 28, 1912



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                            |  |  |  |   |  |  |  | REG. NO. 19175   |  |
|---|--|----------------------------|--|--|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |                            |  |  |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ruth Tighe</b>   |  |                            |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>7 26 82</b>   |  | 2b. HOUR <b>5P</b>   |  |  |  |
| 3. SEX <b>F</b>   |  | 4. RACE <b>W</b>           |  | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>6</b> YEAR <b>03</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>79</b> YRS.   |  | IF UNDER 1 YR.<br>MONTHS <b>7</b> DAYS <b>26</b> HOURS <b>82</b> MIN <b>19</b>   |  | 2c. DATE PRONOUNCED DEAD <b>7 26 82</b>                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  |                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Pr. Geo.</b>                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Chapel Oak</b>  |  |                            |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1309 Early Oaks La Chapel Oak</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Nurse</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>County</b>                       |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                            |  |  |  |   |  |  |  |  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>P.G.</b> |  | 13c. CITY OR TOWN<br><b>Chapel Oak</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  | 13e. STREET ADDRESS<br><b>1309 Early Oak Lane</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Michael</b> MIDDLE <b></b> LAST <b>Tighe</b>  |  |                            |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b></b> MIDDLE <b></b> LAST <b></b>                         |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  |                            |  | 16b. SOCIAL SECURITY NO.<br><b>213-38-0723T</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Route 5, Box 492T<br/>Mr. Richard A. Day, III LaPlata, Md.</b> |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4408</b> IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Rx of Asr</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>  |  |                            |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                            |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                 |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN   |  | COUNTY STATE   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                            |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>SAND A. DARR MO</b>   |  |                            |  | TITLE (SPECIFY)<br><b>Deputy</b>   |  |   |  | MEDICAL EXAMINER   |  | DATE SIGNED <b>7-26-82</b>   |  |
| EXAMINER'S NAME (TYPE OR PRINT) ADDRESS   |  |                            |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>   |  |                            |  | 23b. DATE<br><b>7/27/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>  |  |                            |  |  |  | ADDRESS<br><b>Balto., Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 3 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>James J. [Signature]</i>                |  |

BP

DMMH - 17  
(VR A15 ME (5))  
15M 7/76

2024

FILE

2024

FILE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 9 1 7 6

REG. NO.

|   |  |   |   |   |  |   |  |  |  |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGARET E. TRAUTMAN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7/23/82</b> |   |  | 2b. HOUR<br><b>2:45 P.M.</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 13, 1900</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George's County MD</b>                        |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Adelphi</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Manor Care Nursing Home-Adelphi</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Clerk</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Lynn Animal Hosp.</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>P.G.</b>  |   | 13c. CITY OR TOWN<br><b>Hyattsville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>6116 42nd. Place</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Daniel W. Higgins</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna C. Bender</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>579-05-0029</b>   |   | 17. INFORMANT<br>ADDRESS <b>Address Same as</b><br><b>Mr. Carlisle H. Blanchard No# 13e.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>3352</b> <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Aspiration</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pulmonary edema</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b><br><b>6 weeks</b><br><b>3 yr</b> |  |   |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Lung Abscess</b>   |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (i) (this hospital) attended the deceased from <b>April 8, 1982</b> to <b>22 July, 1982</b> , that (I) (we) last saw the deceased alive on <b>July 22, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I) did not view the body after death.   |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>J. Kelman, M.D.</b>  |  |   |   | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>7/23/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. Kelman, M.D.</b>   |  |   |   | 22e. ADDRESS<br><b>6525 Belcrest Road - Hyattsville, Md.</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7-26-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland P.G. Maryland</b>                     |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 27 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>  |  |  |  |

BP



|          |        |               |                                    |
|----------|--------|---------------|------------------------------------|
| Female   | White  | Dec. 15, 1900 | 81                                 |
| Abelphi  | U.S.A. | x             | Prince George's County             |
| Maryland | F.C.   | Hyattsville   | x                                  |
| Daniel   | W.     | Higgins       | Anna                               |
|          |        |               | C.                                 |
|          |        |               | London                             |
|          |        |               | Address same as                    |
|          |        |               | Mr. Carlisle B. Blanchard No. 120. |

F. Jacob's Sons F.H. P.A. Hyattsville, Md.  
 7-25-82  
 Cedar Hill Cemetery  
 2411 and  
 F.C. Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |   |  |  |  |  |                      |
|--|--|---|--|--|---|--|--|--|--|----------------------|
| 1 - FOR STATE REGISTRAR  |  |   |  |  |   |  |  |  |  |                      |
| CERTIFICATE OF DEATH   |  |   |  |  |   |  |  |  |  |                      |
| REG. NO.   |  |   |  |  |   |  |  |  |  |                      |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Louise T. Turner  |  |   |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>July 14, 1982             |  |  |  |  | 2b HOUR<br>2:00 a.m. |
| 3 SEX<br>Female  |  | 4 RACE<br>Cauc.   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>August 9 1902   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>79   |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |                      |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 9b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Prince George's MD.                                     |  |  |  |                      |
| 10 CITY OR TOWN OF DEATH<br>Riverdale  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Leland Memorial Hospital |  |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |                      |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |   |  |  |  |  |                      |
| 13a STATE<br>Maryland  |  | 13b COUNTY<br>Prince Geo.   |  | 13c CITY OR TOWN<br>Hyattsville  |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br>3450 Toledo Terrace #313   |  |                      |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>McCormick Taylor  |  |   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary E. Plummer |  |  |  |  |                      |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-18-5837   |  | 17 INFORMANT ADDRESS<br>Dorothy Turner 3450 Toledo Terr. Maryland Hyattsville  |   |  |  |  |  |                      |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |  |   |  |  |  |  |                      |
| PART I. DEATH WAS CAUSED BY.   |  |   |  |  |   |  |  |  |  |                      |
| 4140 IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST   |  |   |  |  |   |  |  |  |  |                      |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |   |  |  |  |  |                      |
| (b) ARTERIO SCLEROTIC HEART DISEASE  |  |   |  |  |   |  |  |  |  |                      |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |   |  |  |  |  |                      |
| (c) HYPERTENSION   |  |   |  |  |   |  |  |  |  |                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |   |  |  |  |  |                      |
| AORTIC STENOSIS, CONGESTIVE HEART FAILURE  |  |   |  |  |   |  |  |  |  |                      |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |  |                      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |  |                      |
| 22a. I certify that (I) (this hospital) attended the deceased from June 20, 1982, to July 14, 1982, that (I) (we) lost saw the deceased alive on July 14, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |  |  |  |  |                      |
| 22b. SIGNATURE<br>A. Mehta   |  |   |  | DEGREE<br>ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |   |  |  | 22c. DATE SIGNED<br>7-14-82  |  |                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Arvind Mehta, M. D.   |  |   |  | 22e. ADDRESS<br>3700 East West Highway, Hyattsville, Md.   |   |  |  |  |  |                      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal  |  | 23b. DATE<br>7/16/1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Georgetown Med. School   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Washington, D.C.                                 |  |  |  |                      |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br>Columbia Mortuary Services, Inc.<br>225 Missouri Ave. NW Washington, D.C.   |  |   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 27 1982   |  |  |  |                      |
| 25b. REGISTRAR'S SIGNATURE<br>James San Martin   |  |   |  |  |   |  |  |  |  |                      |

MEDICAL CERTIFICATION

99

5901

BP



RECEIVED  
JAN 15 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |
| REG. NO. 8 2 1 9 1 7 8   |  |   |  |   |  |   |  |  |  |
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Geeta B. UDGAONKAR   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>July 17, 1982   |  | 2b. HOUR<br>2:13a.m.   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>East Indian  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>August 9, 1958   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>23 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Patna, India  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>India   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince George MD  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Lanham  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Doctor's Hospital of Pr. George Co. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Student-University of Maryland |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Prince George  |  | 13c. CITY OR TOWN<br>Greenbelt  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>9132-Edmonston Terrace  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Balchandra M. Udgaoonkar  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Padma A. Altekar  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-94-3143  |  | 17. INFORMANT ADDRESS<br>Jayant B. Udgaoonkar (Brother) Same as #13   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>0362 IMMEDIATE CAUSE (a) Cardiac arrest.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Hypertension<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Meningococcemia<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Disseminated intravascular coagulation  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 14, 1982, to July 17, 1982, that (I) (we) last saw the deceased alive on July 16, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Prudh  |  |   |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  | 22c. DATE SIGNED<br>7/17/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PADMAJA UDAPI   |  |   |  | 22e. ADDRESS<br>5711 Sarvis Avenue, #300 Riverdale MD. 20840  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>July 18, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lee's Crematory   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Washington, D.C.                                     |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>J.Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002   |  |   |  | 25a. DATE REC'D BY REGISTRAR (M)  |  | 25b. REGISTRAR'S SIGNATURE<br>James J. Nathan   |  |  |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 19179

Item #5 per phone call w/Fm  
1- STATE Home 7/26/82 rc  
REGISTRAR

|   |                         |   |   |   |   |   |   |   |  |  |                          |
|---|-------------------------|---|---|---|---|---|---|---|--|--|--------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Clarence Edward Upton</b>   |                         |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/><br><b>7 21 82</b>                                 |   |   | 2b. HOUR<br>DAY <input type="checkbox"/> YEAR <input type="checkbox"/><br><b>19 450 M</b>   |   |   |  |  |                          |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>(LAST BIRTHDAY)<br>MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/><br><b>June 6, 1908</b> | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/><br><b>74 YRS.</b> | IF UNDER 1 YR.<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>   | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN <input type="checkbox"/> | 7c. DATE PRONOUNCED DEAD<br>MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/><br><b>7 21 82</b> |   |   | 2d. HOUR<br>DAY <input type="checkbox"/> YEAR <input type="checkbox"/><br><b>19 1225 P M</b> |  |                          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George's County</b> MD.   |   |   |  |  |                          |
| 10. CITY OR TOWN OF DEATH<br><b>College Park</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>9710 Rhode Island Ave.</b>             |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Printer</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov't.</b> |  |  |                          |
| 13a. STATE<br><b>Maryland</b>   |                         |   | 13b. COUNTY<br><b>P.G.</b>  |   | 13c. CITY OR TOWN<br><b>College Park</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>9710 Rhode Island Ave.</b>   |  |                          |
| 14. FATHER'S NAME<br>FIRST <input type="checkbox"/> MIDDLE <input type="checkbox"/> LAST <input type="checkbox"/><br><b>William Chester Upton</b>   |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <input type="checkbox"/> MIDDLE <input type="checkbox"/> LAST <input type="checkbox"/><br><b>Elizabeth E. Flynn</b>                               |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes-Navy Peacetime</b>          |   |   |  | 16b. SOCIAL SECURITY NO.<br><b>331-14-7762</b> |                          |
| 17. INFORMANT<br><b>Mrs. Vivian C. Upton</b>  |                         |   | ADDRESS<br><b>Address Same as No# 13e.</b>  |   |   |   |   |   |  |  |                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>hypertension</b>  |                         |   |   |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |   |   |   |   |   |   |   |  |  |                          |
| 19a. DATE OF OPERATION  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  |                          |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |  |  |                          |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   |   | 21f. LOCATION<br>STREET   |   | CITY OR TOWN  |  | STATE  |                          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |   |   |   |   |   |   |   |  |  |                          |
| ACTUAL SIGNATURE<br><b>Said A. Dae M.</b>   |                         |   | M.D. <b>Deputy</b>  |   |   | MEDICAL EXAMINER<br><b>5632 Annapolis Road, Suite # 4</b>   |   |   | DATE SIGNED<br><b>7-21-82</b>  |  |                          |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Said A. Dae, M.D.</b>  |                         |   | ADDRESS<br><b>Bladensburg, Maryland</b>   |   |   |   |   |   |  |  |                          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |                         |   | 23b. DATE<br><b>7-22-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Crematory</b>              |   |   | 23d. LOCATION<br>CITY OR TOWN<br><b>Brentwood</b>       |  | COUNTY<br><b>P.G.</b>                          | STATE<br><b>Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>F. Gasch's Sons F.H. P.A.</b>  |                         |   |   |   |   | ADDRESS<br><b>Hyattsville, Md.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 26 1982</b>     |  | 25b. REGISTRAR<br><b>James J. [Signature]</b>  |                          |

MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

*[Faint, illegible text at the bottom of the page]*

2010-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |           |   |   |   |  |  |                                   | 8 2 1 9 1 8 0   |  |  |
|---|--|---|-----------|---|---|---|--|--|-----------------------------------|---|--|--|
| 1 - FOR<br>STATE<br>REGISTRAR   |  |   |           |   | REG. NO.                                      |   |  |  |                                   |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |           |   | 2a. DATE OF DEATH                             |   |  |  |                                   | 2b. HOUR  |  |  |
| FIRST MIDDLE LAST<br>RALPH Carrington VIOLETT   |  |   |           |   | MONTH DAY YEAR<br>July 10 '82                 |   |  |  |                                   | 12.57PM   |  |  |
| 3. SEX  |  | 4. RACE   |           | 5. DATE OF BIRTH  |   |   | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |  | IF UNDER 1 YEAR                   |   |  |  |
| MALE  |  | WHITE   |           | MONTH DAY YEAR<br>March 31, 1911  |   |   | 71   |  | MONTHS DAYS HOURS MIN.            |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |  |                                   |   |  |  |
| Virginia  |  | U.S.A.  |           |   |   |   | Prince George MD.  |  |                                   |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |           |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |  |
| Clinton   |  | Southern Maryland Hospital  |           |   |   |   | Call Clerk   |  | Electric Co.                      |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |           |   | 13d. INSIDE CITY LIMITS?                      |   | 13e. STREET ADDRESS  |  |                                   |   |  |  |
| 13a. STATE  |  | 13b. COUNTY   |           | 13c. CITY OR TOWN   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | 8507 Timothy Road  |                                   |   |  |  |
| Maryland  |  | P.G.  |           | Brandywine  |   |   |  |  |                                   |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   |           |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST |   |  |  |                                   |   |  |  |
| Claude R. Violet  |  |   |           |   | Grace Wood                                    |   |  |  |                                   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |   |           |   | 16b. SOCIAL SECURITY NO.                      |   | 17. INFORMANT ADDRESS  |  |                                   |   |  |  |
| NO  |  |   |           |   | 579-05-8065                                   |   | 3003 Ashwood Drive<br>Ralph T. Violet Dunkirk, Md.               |  |                                   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY   |  |   |           |   |   |   |  |  |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |
| IMMEDIATE CAUSE (a) 4140 CARDIOPULMONARY ARREST   |  |   |           |   |   |   |  |  |                                   | HOURS.  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |           |   |   |   |  |  |                                   |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |           |   |   |   |  |  |                                   | YEARS.  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |           |   |   |   |  |  |                                   |   |  |  |
| (c) CHRONIC OBSTRUCTIVE PULMONARY DISEASE   |  |   |           |   |   |   |  |  |                                   | YEARS.  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |  |   |           |   |   |   |  |  |                                   |   |  |  |
| HYPERTENSIVE CARDIOVASCULAR DISEASE. TRIFASCICULAR HEART BLOCK  |  |   |           |   |   |   |  |  |                                   |   |  |  |
| 19a. DATE OF OPERATION  |  |   |           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |                                   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |           | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |                                   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-24-81, 19____, to July 10'82, 19____, that (I) (we) lost saw the deceased alive on July 10, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |           |   |   |   |  |  |                                   |   |  |  |
| 22b. SIGNATURE  |  |   |           | DEGREE  |   |   |  | 22c. DATE SIGNED   |                                   |   |  |  |
| Peter W. Yim  |  |   |           | M.D.  |   |   |  | July 10 1982   |                                   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |           | 22e. ADDRESS  |   |   |  |  |                                   |   |  |  |
| PETER W. YIM M.D.   |  |   |           | 7900 OLD BRANCH AVE. SUITE 101<br>CLINTON, MARYLAND 20735   |   |   |  |  |                                   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   | 23b. DATE |   | 23c. NAME OF CEMETERY OR CREMATORY            |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |                                   |   |  |  |
| Burial  |  |   | 7-14-82   |   | Ft. Lincoln Cem.                              |   |  | Colmar Manor P.G., Md.   |                                   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  |   |           | 25a. DATE REC'D. BY REGISTRAR   |   |   |  | 25b. REGISTRAR'S SIGNATURE   |                                   |   |  |  |
| Hunt Funeral Home Waldorf, Maryland   |  |   |           | JUL 14 1982   |   |   |  | Thomas G. North  |                                   |   |  |  |

on

Virginia U.S.A. x

Clinton Southern Maryland Hospital - Call Mark

Review 1.8. x Brandysine

Claude R. Violet

NO 572-02-8088 Helen T. Violet 3802 Richmond Drive Dunkirk, Md.

curial 7-14-82 Ft. Lincoln Cem. Collier Manor, D.C., Md.

Grant Funeral Home, Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Evelyn L. Wallingsford</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 11 82</b>                             |  | 2b. HOUR<br>MIN.<br><b>8:45</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>January 24, 1914</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George's</b> MD.                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Clinton</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Southern Maryland Hospital Center</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>at home</b>  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b><br>13b. COUNTY<br><b>Pr. George</b><br>13c. CITY OR TOWN<br><b>Oxon Hill</b><br>13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>13e. STREET ADDRESS<br><b>714 Leyte Place</b>   |  |   |  |   |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward Boileau</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth O'Connor</b> |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>577-01-4807</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Marlene Dewey 714 Leyte Place Oxon Hill, Maryland</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4292 Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Advanced Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>10 years</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Severe Ch. pling Rheumatoid Arthritis, Diabetes Mellitus</b>  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>7-12</b> 19 <b>82</b> to <b>7-14</b> 19 <b>82</b> that (I) (we) lost<br>saw the deceased alive on <b>7-12</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>David N. Robb</b>  |  |   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>David N. Robb, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>9401 Indian Head Highway, Ft. Wash., Md.</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7/13/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood P.G. Maryland</b>         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George P. Kalas Funeral Home</b>   |  |   |  | ADDRESS<br><b>6160 Oxon Hill Rd. Oxon Hill, Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 16 1982</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Francis</b>   |  |

George E. Wilson Funeral Home  
 6180 Oxon Hill Rd.  
 Oxon Hill, Md.  
 7/13/82  
 Ft. Lincoln Cemetery  
 Brentwood, D.C., Maryland  
 David M. Kopp, M.D.  
 9401 Indian Road Highway, 74, Wash., Md.

No  
 277-01-1807  
 Mariens Lewy  
 Elizabeth  
 Howard  
 774 Fayette Place  
 Oxon Hill, Maryland  
 O'Connor

Maryland  
 Dr. George Oxon Hill  
 x  
 774 Fayette Place

Union  
 Southern Maryland Hospital Center  
 at home

Virginia  
 U.S.A.  
 x  
 Prince Georges

female  
 Caucasian  
 28 January 24, 1918

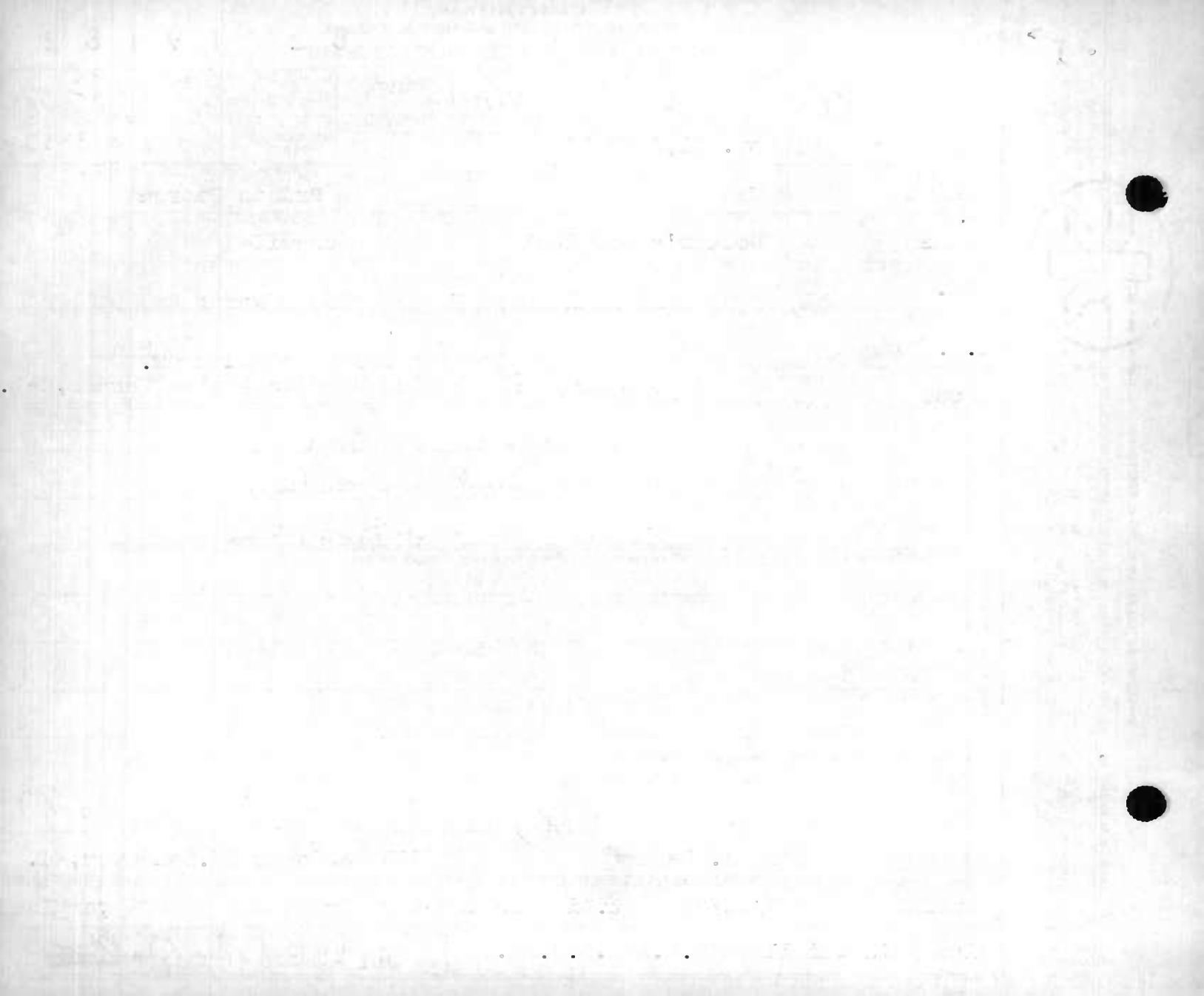
Wilmington  
 L.  
 Evelyn



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |   |   |   |   |   |  |  |  | REG. NO. 19182                               |  |
|---|-------------------------|---|---|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PEN Lu Wang</b>  |                         |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>7 20 82</b>         |   |   | 2b. HOUR <b>5:20</b>  |  |  |  |  |  |
| 3. SEX <b>F</b>   | 4. RACE <b>Oriental</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Nov. 21, 1907</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>74</b>           | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN'  | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD <b>7 20 82</b>                                       |  | 2d. HOUR <b>5:20</b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>China</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b>                     |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Lanham</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Doctor's Hospital</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE <b>Md.</b>   |                         |   | 13b. COUNTY <b>PG</b>                                       |   | 13c. CITY OR TOWN <b>Adelphi</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>9250 Edwards Way</b>                              |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>C.T. Ming</b>   |                         |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>UNK Chao</b>   |   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>None</b>   |                         |   | 16b. SOCIAL SECURITY NO. <b>214 607453</b>                  |   | 17. INFORMANT <b>28509 Seamount Dr. Charles Wang (Son) Palos Verdes, Cal.</b> |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>Myocardial infarction</b><br>(b) <b>ASVD</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Cholestasis</b><br>(c)                       |                         |   |   |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |                         |   |   |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |   |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |   |   |   |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Said A. Daem</b>  |                         |   | TITLE (SPECIFY) <b>Deputy</b>                               |   |   | MEDICAL EXAMINER  |  |  | DATE SIGNED <b>7-20-82</b>   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Said A. Daem</b>  |                         |   | ADDRESS <b>6490 Landover Rd. Landover, Md.</b>              |   |   |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>   |                         |   | 23b. DATE <b>7/22/82</b>                                    |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>                |   |  | 23d. LOCATION<br>STREET CITY OR TOWN COUNTY STATE <b>Brentwood PG Maryland</b> |  |  |  |
| 24. FUNERAL DIRECTOR <b>Hines/Rinaldi 11800 N.H. Ave. S.S. Md.</b>  |                         |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR <b>JUL 29 1982</b>                              |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                                  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 9 1 8 3

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |  |   |  |   |   |  |  |  |
|---|--|---|---|--|---|--|---|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Clara E. Warner</b>  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>7-6-82</b>                   |  |   | 2b HOUR<br><b>2:55A.M.</b>   |   |   |  |  |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>CAUCASIAN</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>DEC 30 1890</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS  |   | 7 IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>  |  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>CONN</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>PRINCE GEORGE'S COUNTY MD.</b>   |   |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>ADELPHI</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MANOR CARE NURSING HOME</b> |   |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MARYLAND</b>   |  |   | 13b COUNTY<br><b>PRINCE GEO</b>                                       |  | 13c CITY OR TOWN<br><b>LAUREL</b>                               |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e STREET ADDRESS<br><b>10470 GRAELOCH ROAD</b> |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HERMAN ROTH</b>   |  |   |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>HENRIETTA</b>   |   |  |   |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   | 16b SOCIAL SECURITY NO.<br><b>047-30-9458</b>                         |  | 17 INFORMANT<br><b>ROY WARNER</b>                               |  | ADDRESS<br><b>10470 GRAELOCH ROAD<br/>LAUREL, MD. 20707</b>                         |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a)<br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Arterio sclerotic Heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 years</b>   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Cerebrovascular disease, Osteoarthritis</b>  |  |   |   |  |   |  |   |   |  |  |  |
| 19a DATE OF OPERATION   |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |   |  |   |   |  |  |  |
| 22b SIGNATURE<br><b>[Signature]</b>   |  |   | DEGREE  |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c DATE SIGNED<br><b>7/6/82</b>  |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>IBRAHIM M. KHATRI</b>  |  |   |   |  | 22e ADDRESS<br><b>6525 Belcrest Rd Hyattsville Md</b>           |  |   |   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |   | 23b DATE<br><b>JULY 8, '82</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>BEAVERDALE MEM PARK</b> |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>HAMDEN CONN</b>                     |   |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>HARRY H. WITZKE</b>   |  |   | 4112 COLUMBIA ROAD<br>ELLICOTT CITY, MD 21043                         |  |   | 25a DATE REC'D. BY REGISTRAR<br><b>JUL 7 1982</b>  |   | 25b REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |

Class

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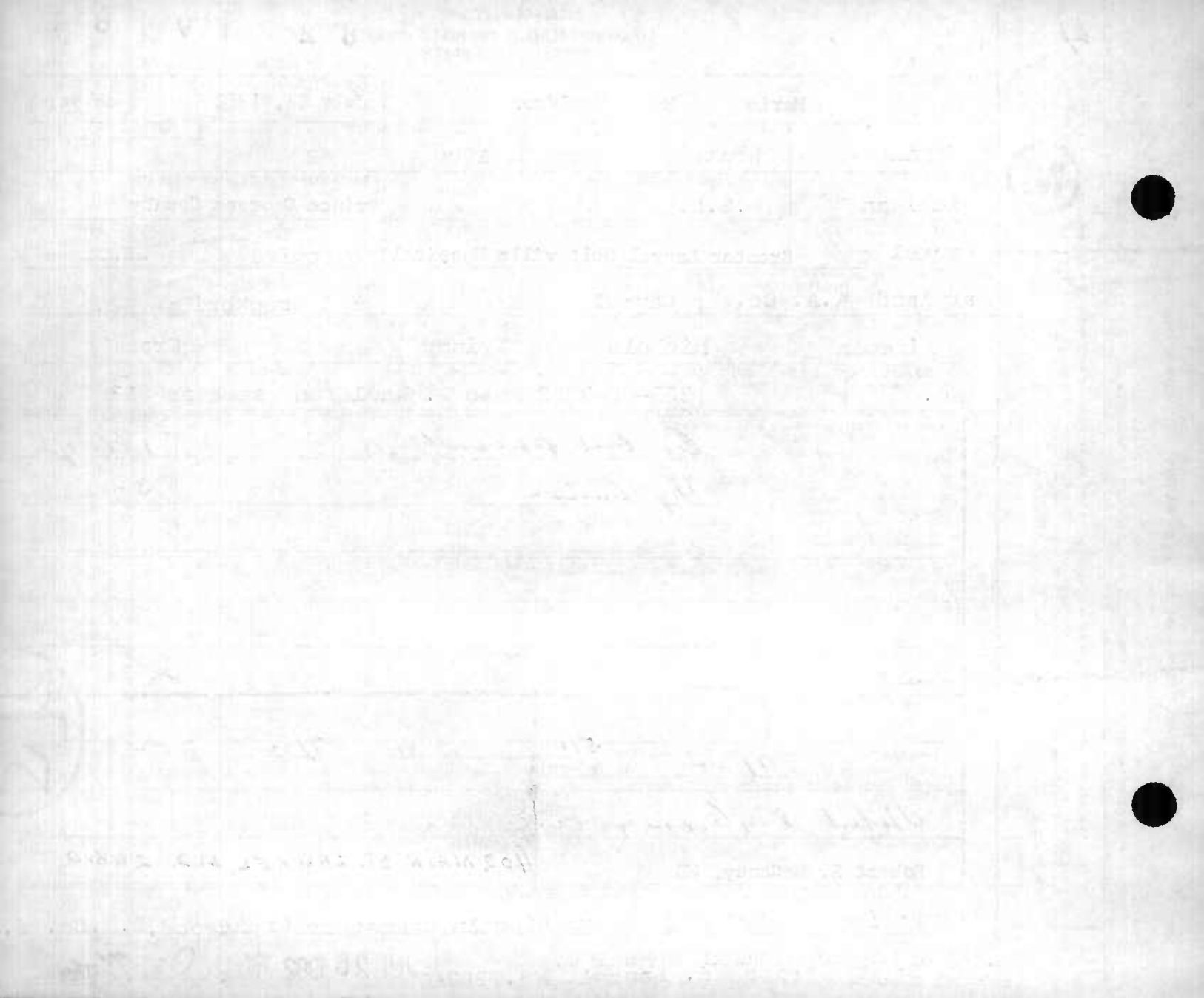
NAME

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |   |   |  |   |  |   |   |  |  |
|---|--|---|---|---|--|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR  |  |   |   |   | 8 2 1 9 1 8 4<br>REG. NO.  |   |  |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Marie M Wauldron</b>   |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>July 22, 1982</b>                                       |   |  | 2b. HOUR<br><b>9:25A</b> M  |   |  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>May 3, 1900</b>   |  | 6 AGE (IN YEARS (LAST BIRTHDAY))<br><b>82</b> YRS.                                |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Michigan</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges County</b> MD.          |  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Laurel</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Laurel Beltsville Hospital</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>                         |   |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |   |   |   | 13b. COUNTY<br><b>A.A. Co.</b>   |   | 13c. CITY OR TOWN<br><b>Laurel</b>                                     |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Lincoln Nichols</b>   |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ginny Oram</b>                                |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No.</b>   |  |   |   |   | 16b. SOCIAL SECURITY NO.<br><b>365-09-7282</b>   |   | 17. INFORMANT ADDRESS<br><b>Ross B. Wauldron same as #13</b>           |   |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4310</b> IMMEDIATE CAUSE (a) <b>Coronary heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>-----</b> |  |   |   |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>3 years</b>  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>-----</b>   |  |   |   |   |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                 |   |  |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/1</b> , 19 <b>81</b> , to <b>7/22</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>7/22</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                         |  |   |   |   |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Robert S. McCeney, MD</b>  |  |   |   |   | DEGREE<br><b>MD</b>  |   |  | 22c. DATE SIGNED  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert S. McCeney, MD</b>   |  |   |   |   | 22e. ADDRESS<br><b>402 MAIN ST. LAUREL, MD. 20810</b>  |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  |   | 23b. DATE<br><b>7/26/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Crematory</b>                            |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Brendwood, P.G. Co. Md.</b> |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>FLECK LAUREL FUNERAL HOME INC.</b>   |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JUL 26 1982 James J. Nathan</b> |   |  |   |   |  |  |
| 26. ADDRESS<br><b>7601 Sandy Spring Rd. Laurel, Md. 20707</b>   |  |   |   |   |  |   |  |   |   |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                                     |  |   |  |   |  |   |  | REG. NO. 82 19185  |  |   |  |
|---|--|-------------------------------------|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN GUY WEBB</b>  |  |                                     |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>7/19/ 19 82</b>                                |  | 2b. HOUR<br><b>M</b>                                    |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Cauc.</b>             |  | 5. DATE OF BIRTH<br>MONTH <b>June</b> DAY <b>10</b> YEAR <b>1929</b>  |  | 6. AGE IN YEARS<br>LAST BIRTHDAY <b>53</b> YRS.   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br><b>July 19, 1982</b>                                       |  | 2d. HOUR<br><b>6:20 P M</b>                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  |                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges</b> MD.                      |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bowie</b>   |  |                                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>14933 Nighthawk Lane</b> |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>title examiner</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Real Estate</b> |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                                     |  |   |  |   |  |   |  |  |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Prince George</b> |  | 13c. CITY OR TOWN<br><b>Bowie</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>14933 Nighthawk Lane</b>  |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Guy</b> MIDDLE LAST <b>Webb, Jr.</b>  |  |                                     |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Fidelis</b> MIDDLE LAST <b>McLaughlin</b>                  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>no</b>   |  |                                     |  | 16b. SOCIAL SECURITY NO.<br><b>579-30-4864</b>  |  | 17. INFORMANT<br><b>Joanna Marie Webb</b>   |  |   |  | ADDRESS <b>1225 Heartwood Ct Arnold, Md.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>5715 IMMEDIATE CAUSE (a) Cardio respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>hx of cirrhosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>suicide</b>  |  |                                     |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                                     |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                                     |  |   |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Said A. Daee ME</b>   |  |                                     |  | TITLE (SPECIFY) <b>Deputy</b> M.D.  |  |   |  | DATE SIGNED <b>7-20-82</b>  |  |  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Said A. Daee ME</b>  |  |                                     |  | ADDRESS <b>5632 Annapolis Rd., Bladensburg, Md.</b>   |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  |                                     |  | 23b. DATE<br><b>July 20 82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Crematory</b>                              |  |   |  | 23d. LOCATION<br>CITY OR TOWN <b>Brentwood</b> COUNTY <b>Maryland</b> STATE            |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Beall Funeral Home</b> ADDRESS <b>16000 Annapolis</b>   |  |                                     |  | DATE REC'D. BY REGISTRAR <b>JUL 22 1982</b>   |  |   |  | REGISTRAR'S SIGNATURE <b>James J. Nathan</b>  |  |  |  |   |  |



FILE NO. 10-198

1337

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32712

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 9 1 8 6

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>NORA Mary WELCH  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>07 11 82                               |   | 2b. HOUR<br>11:10 P.M.   |
| 3. SEX<br>female   | 4. RACE<br>white   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>06 - 22 - 1931  |   | 6. AGE<br>(IN YEARS (LAST BIRTHDAY))<br>51 YRS.                                       | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince Georges MD.                            |  |
| 10. CITY OR TOWN OF DEATH<br>Clinton   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Southern Maryland Hospital Center |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY<br>at home  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Charles  | 13c. CITY OR TOWN<br>Indian Hd.   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Wesley Hart   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Viola Virginia Polliam   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>228-34-4468   |   | 17. INFORMANT<br>ADDRESS<br>Rt. #1, Box 1201-H<br>Joyce Ann Bowie-La Plata, Md. 20646 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>1749 IMMEDIATE CAUSE (a) <u>Carcinoma of St Breast</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Metastasis to lungs, Bones</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/6</u> , 19 <u>82</u> , to <u>7/14</u> , 19 <u>82</u> .<br>I saw the deceased alive on <u>7/11</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |
| 22b. SIGNATURE<br><u>R. E. 20 MORTON</u>   |  | DEGREE  |   | 22c. DATE SIGNED<br>7/12/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R E 20 MORTON   |  | 22e. ADDRESS<br>4235 25th Ave N.E. 20031  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>7-15-1982  | 23c. NAME OF CEMETERY OR CREMATORY<br>Trinity Mem. Gardens                    |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Waldorf, Charles, Md.  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Arehart Funeral Home   |  | 211 St. Mary's Ave.<br>La Plata, MD.  |   | 25a. DATE RECD. BY REGISTRAR<br>JUL 20 1982   |  |

MEDICAL CERTIFICATION

9 9

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |  |  |  |                              | 8 2 1 9 1 8 7  |  |
|--|--|--|--|---|--|--|--|--|------------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |  |  |  |                              | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JAMES K. WHEATLEY</b>  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>07-12-82</b>                            |  |  | 2b. HOUR<br><b>9:20 P.M.</b> |  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>08 08 28</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS.                              |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 72 HRS. HOURS MIN.   |                              |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>PRINCE GEORGE'S COUNTY MD</b>       |  |  |                              |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CHEVERLY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PRINCE GEORGE'S GENERAL HOSP.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Welder</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Fence Mfg</b>  |                              |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  |  | 13b. COUNTY<br><b>Prince Geo</b>  |  | 13c. CITY OR TOWN<br><b>Ritchie</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              | 13e. STREET ADDRESS<br><b>2015 Elmwood Park Dr.</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William H. Wheatley</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary E. Cundiff</b>  |  |  |  |  |                              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>None</b>   |  | 17. INFORMANT<br><b>Garaldine Wheatley</b>                                     |  | ADDRESS<br><b>see 13 E.</b>  |                              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bilateral Pneumococcal Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hepatic Degeneration</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>5728</b> |  |  |  |   |  |  |  |  |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b><br><b>2 1/2 weeks</b><br><b>5 weeks</b>                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (iii)<br><b>Bone marrow hypoplasia</b>   |  |  |  |   |  |  |  |  |                              |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART 2)          |  |  |                              |  |  |
| 21d. INJURY OCCURRED<br>UPPER <input type="checkbox"/> LOWER <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |                              |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>6-27 1982</b> to <b>7-12 1982</b> that (we) last saw the deceased alive on <b>7-12 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |                              |  |  |
| 22b. SIGNATURE<br><b>Thomas G. Maloney MD</b>  |  |  |  |   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                              | 22c. DATE SIGNED<br><b>13 Jul 82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thomas G. Maloney, M.D.</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>4814-71st Ave. Hyattsville, Md.</b>                         |  |  |                              |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>7-15-1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b>                 |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Rockville, Montgomery Co. Md.</b>  |                              |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>W. W. Chambers Co, 8655 Georgia Ave, Sil. Spg</b>  |  |  |  |   |  | ADDRESS<br><b>JUL 19 1982</b>  |  | 25a. DATE RECD. BY REGISTRAR<br><b>JUL 19 1982</b>   |                              |  |  |

DATE: 07-11-10 TIME: 10:00 AM

TO: Mr. J. Edgar Hoover  
FROM: Mr. [Name]  
SUBJECT: [Subject]  
[Body text of the letter, mostly illegible]

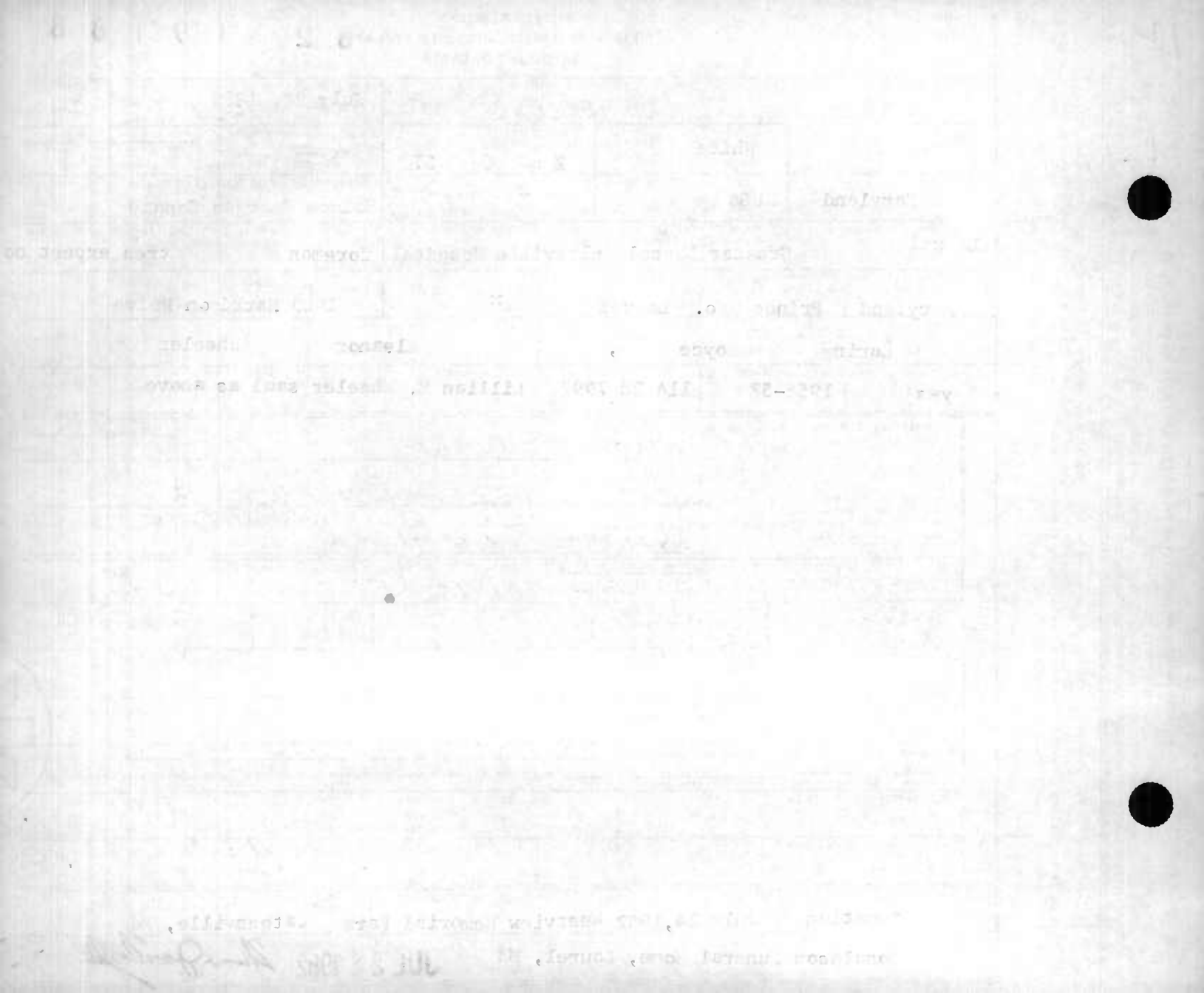
Very truly yours,  
[Signature]  
[Name]  
[Title]  
[Address]

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 2 1 9 1 8 8   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH   |  |  |  |
| MELVIN L. WHEELER   |  |  |  | July 22, 1982   |  |  |  |
| 3 SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| M   |  | White  |  | 4 8 37  |  | 45 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| Maryland  |  | USA  |  |   |  | Prince Georges County MD                                       |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| Laurel  |  | Greater Laurel Beltsville Hospital   |  |   |  | foreman  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  | tree expert co  |  |  |  |
| 13a. STATE  |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  |
| Maryland  |  |  |  | Prince Geo.   |  | Laurel   |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)   |  |  |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)  |  |  |  |
| Loring Boyce  |  |  |  | Eleanor Wheeler   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO. (GIVE WORK DATES)  |  | 17. INFORMANT ADDRESS  |  |
| yes   |  |  |  | 1954-57   |  | 114 28 7997 Lillian M. Wheeler same as above                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (a) CARDIAC ARREST  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS PERFORATION DUODENAL  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) ULCER, CROHN'S DISEASE LYMPHOMA IN REMISSION   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: STATUS POST ABDOMINOPERINEAL RESECTION FOR CROHN'S   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| 6-21-82   |  | CROHN'S DISEASE OF COLON + SMALL BOWEL   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
|   |  | P.M. 19  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
|   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-17-82, 19 to 7-22-82, 19 that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE  |  | 22c. DATE SIGNED   |  |
| Felix Flores, M.D.  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 7-22-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |  |  |
| FELIX FLORES  |  |  |  | 14201 LAUREL PARK DRIVE LAUREL, MD. 20707   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Cremation   |  | July 24, 1982  |  | Westview Memorial Park  |  | Catonsville, Md  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |  |  |
| Donaldson Funeral Home, Laurel, Md  |  |  |  | JUL 28 1982   |  |  |  |





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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |   |                             |  |  |
|--|--|---|---|---|-----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Lee J. Whitehead</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 17, 1982</b> |   | 2b. HOUR<br><b>4:00A.M.</b> |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>December 19, 1909</b>  |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b><br>YRS. MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George's County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Laurel</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Laurel Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Deliveryman</b>  |                             | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Auto Parts</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>P.G.</b>  |   | 13c. CITY OR TOWN<br><b>College Park</b>  |                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>9549 Rhode Island Ave.</b>   |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George P. Whitehead</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Daisy B. Riddle</b>   |                             | 16. ADDRESS<br><b>Address Same as No# 13e.</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-14-2577A</b>   |   | 17. INFORMANT<br><b>Ethel M. Beveridge</b>  |                             | 18. ADDRESS<br><b>Address Same as No# 13e.</b>   |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>one year</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>one year</b>  |  |   |   |   |                             |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Benign prostatic enlargement</b>  |  |   |   |   |                             |  |  |
| 19a. DATE OF OPERATION<br><b>May 82</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>prostatic enlargement</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                             |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                             |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/29/1982</b> to <b>7/16/1982</b> , that (I) (we) last saw the deceased alive on <b>6/16/1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |   |                             |  |  |
| 22b. SIGNATURE<br><b>A. ZHER</b>   |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                             | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>AZHER HUSSAIN</b>  |  | 22e. ADDRESS<br><b>4917 Edgewood Road College park MD</b>   |   |   |                             |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>July 20, 1982</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. John's Epis. Ch. Cem.</b>  |                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Beltsville P.G. Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>  |  | 25a. DATE REC'D BY REGISTRAR<br><b>JUL 20 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |                             |  |  |



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 E.  
 Address same as  
 No

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 9 1 9 0

REG. NO.

|  |  |  |  |   |  |  |   |   |  |  |  |
|--|--|--|--|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MARJORIE L. WILCOX  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 17, 1982                   |   |  | 2b. HOUR<br>6:10 AM  |   |   |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 21, 1927   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>54 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                            |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince George's County, MD.  |   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Clinton   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Southern Maryland Hospital Center |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Secretary  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Government                    |  |  |  |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Pr. George's  |   | 13c. CITY OR TOWN<br>District Heights  |  | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>7005 Kipling Parkway  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William R. Lovell  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mabel E. Shell   |  |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A         |   | 17. INFORMANT<br>Sharon Blair  |  | ADDRESS<br>1711 Aberdeen Court<br>Crofton, Maryland 21114                                   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>anoxia</u><br><u>1629</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>lung cancer metastatic to brain</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |  |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |   |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>July 16, 1982</u> to <u>July 17, 1982</u> , that (1) we lost <u>the deceased</u> above, and that in my (our) opinion death occurred on the <u>date</u> and hour and from the causes stated above, (1) (we) did not view the body after death.  |  |  |  |   |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  |  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>7/17/82</u>                                      |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Dr. H. A. DAK</u>  |  |  |  | 22e. ADDRESS<br><u>[Address]</u>  |  |  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>July 20, 1982   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Resurrection Cemetery                    |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Clinton, Pr. George's, MD |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lee Funeral Home, Inc.   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>35 JUL 21 1982  |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                        |  |  |  |



BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSMIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |                            |                        |   |  |   |  |   |                      |   |  |  |  |  |                           |  |  |
|---|--|----------------------------|------------------------|---|--|---|--|---|----------------------|---|--|--|--|--|---------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                            | FIRST<br><b>Austin</b> |   |  | MIDDLE<br><b>T.</b>   |  |   | LAST<br><b>Wiles</b> |   |  | 2a. DATE KNOWN OF DEATH<br>EST. MATED <input type="checkbox"/> <b>July 24</b> 19 <b>82</b> |  |  | 2b. HOUR<br><b>8 A.M.</b> |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>    |                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug 28, 1902</b>   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>79</b> YRS.  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |                      | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br><b>July 24</b> 19 <b>82</b>                                    |  |  | 2d. HOUR<br><b>9 A.M.</b> |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |                            |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                      |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George's County</b> MD.                  |  |  |                           |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hyattsville</b>   |  |                            |                        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3811 Powhatan Street</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Mechanic</b>  |                      |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Amer. Ice Co.</b>                                  |  |  |                           |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>P.G.</b> |                        | 13c. CITY OR TOWN<br><b>Hyattsville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3811 Powhatan Street</b>  |                      |   |  |  |  |  |                           |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John W.T. Wiles</b>  |  |                            |                        |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ava Castle</b>                              |  |   |                      |   |  |  |  |  |                           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  |                            |                        | 16b. SOCIAL SECURITY NO.<br><b>578-09-2609</b>  |  | 17. INFORMANT<br><b>Mrs. Lillian Wiles</b>  |  |   |                      | ADDRESS <b>Address Same as No# 13e.</b>                               |  |  |  |  |                           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>2500 IMMEDIATE CAUSE (a) Respiratory failure</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Diabetes</b><br>(c) <b>ASVD</b>  |  |                            |                        |   |  |   |  |   |                      |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                           |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |                            |                        |   |  |   |  |   |                      |   |  |  |  |  |                           |  |  |
| 19a. DATE OF OPERATION  |  |                            |                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |                      |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |  |  |                           |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>P.M. 19   |  |                            |                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                      |   |  |  |  |  |                           |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                            |                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                      |   |  |  |  |  |                           |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                            |                        |   |  |   |  |   |                      |   |  |  |  |  |                           |  |  |
| ACTUAL SIGNATURE <b>SAID A. DACE M.D.</b>   |  |                            |                        | TITLE (SPECIFY) <b>Deputy</b>   |  |   |  | MEDICAL EXAMINER<br><b>5632 Annapolis Road, Suite # 4 Bladensburg, Maryland</b>   |                      |   |  | DATE SIGNED <b>July 24, 1982</b>   |  |  |                           |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Said A. Dace, M.D.</b>   |  |                            |                        | ADDRESS   |  |   |  |   |                      |   |  |  |  |  |                           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |                            |                        | 23b. DATE<br><b>7-26-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>                               |  |   |                      | 23d. LOCATION<br>CITY OR TOWN STATE<br><b>Brentwood P.G. Maryland</b> |  |  |  |  |                           |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>   |  |                            |                        | ADDRESS   |  |   |  | 25a. DATE REC'D FOR REGISTRATION<br><b>JUL 28 1982</b>  |                      |   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |                           |  |  |

|             |       |                     |    |                    |             |
|-------------|-------|---------------------|----|--------------------|-------------|
| Male        | White | Age 28, 1902        | W. | Viles              | July 24, 22 |
| Maryland    |       | 1.2.4.              |    |                    |             |
| Hyattsville |       | 7811 Potomac Street |    |                    |             |
| Maryland    |       | 1.2.4.              |    |                    |             |
| John        |       | W.T.                |    | Viles              | July 24, 22 |
| No          |       | 278-62-0000         |    | Mrs. Lillian Viles | July 24, 22 |
|             |       |                     |    | Castle             |             |
|             |       |                     |    | Albion Road 22     |             |
|             |       |                     |    | for 170.           |             |

July 24, 1922

5032 Annapolis Road, Suite 2-A  
Baltimore, Maryland

Said A. 1922, N.D.

7-20-22

W.C. Lincoln Cemetery

Wentwood

July 24, 1922

5032 Annapolis Road, Suite 2-A  
Baltimore, Maryland



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                     |  |   |  |  |  |   |  | REG. NO.   |  |
|---|--|---------------------|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST: EVERETT MIDDLE: WILLIAMS LAST: WILLIAMS   |  |                     |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH: 7 DAY: 24 YEAR: 82  |  | 2b. HOUR<br>14.50<br>P. M.  |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black    |  | 5. DATE OF BIRTH<br>MONTH: DAY: YEAR: 49  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY: 49 YRS.  |  | 7. IF UNDER 1 YR. IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH: 7 DAY: 24 YEAR: 82                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.   |  |                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>F.D. Co. MD.                          |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Maryland   |  |                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6735 New Hampshire Ave. |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Truck Driver |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Tanens appliance                    |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>P.G. |  | 13c. CITY OR TOWN<br>Takoma Park  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>6735 New Hampshire Ave.                                |  |  |  |
| 14. FATHER'S NAME<br>FIRST: Duris EVERETT MIDDLE: BARTON LAST:  |  |                     |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST: Callie MIDDLE: WILLIAMS LAST:   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |                     |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>ADDRESS: Mrs. Joanne Clemons/daughter/same as 13e   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>1629 IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last.<br>(b) <u>Carcinoma of the lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                     |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                     |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |  |                     |  |   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br>SAND A. DAVIS M.D.  |  |                     |  | TITLE (SPECIFY)<br>Deputy MEDICAL EXAMINER  |  |  |  | DATE SIGNED<br>7-24-82  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  |                     |  | ADDRESS   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |                     |  | 23b. DATE<br>7-30-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lincoln Memorial   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, Md.                   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John T. Rhines Co., 3015 12th St., N.E., D.C. 20017   |  |                     |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 30 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>Joanne  |  |  |  |



FILED  
JUN 10 1914

RECEIVED  
JUN 10 1914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |              |   |                                     |  |  |  |  | 7 2 1 9 1 9 3   |  |
|---|--|--|--------------|---|-------------------------------------|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |              |   | CERTIFICATE OF DEATH                |  |  |  |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |              |   | 2a. DATE OF DEATH                   |  |  |  |  | 2b. HOUR  |  |
| FIRST MIDDLE LAST<br>Lawrence J. Williams   |  |  |              |   | MONTH DAY YEAR<br>7-15-82           |  |  |  |  | 7:30 pm   |  |
| 3 SEX   |  | 4 RACE   |              | 5. DATE OF BIRTH  |                                     | 6 AGE (IN YEARS, LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR   |  | 8. IF UNDER 74 HRS.   |  |
| Male  |  | Black  |              | MONTH DAY YEAR<br>August 28, 1908   |                                     | 73 YRS.  |  | MONTHS DAYS  |  | HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |              | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                     | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |   |  |
| Louisiana   |  | USA  |              |   |                                     | Prince George County MD.   |  |  |  |   |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |              |   |                                     | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                      |  |   |  |
| Clinton   |  | Southern Maryland Hospital   |              |   |                                     | Self Employed  |  | -----  |  |   |  |
| 13a. STATE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |              |   | 13b. CITY OR TOWN                   |  | 13c. STREET ADDRESS                                  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| Maryland  |  |  |              |   | Charles Waldorf                     |  | Route 4 Box 77                                       |  |  |   |  |
| 14. FATHER'S NAME   |  |  |              |   | 15. MOTHER'S MAIDEN NAME            |  |  |  |  |   |  |
| FIRST MIDDLE LAST<br>Lawrence Jones   |  |  |              |   | FIRST MIDDLE LAST<br>Beulah Duckett |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES   |  |  |              |   | 16b. SOCIAL SECURITY NO.            |  | 17. INFORMANT ADDRESS                                |  |  |   |  |
| Yes WWII  |  |  |              |   | 496-01-1102                         |  | Barbara P. Minnis 105 14th St. N.E. Washington, D.C. |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.   |  |  |              |   |                                     |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 4100 IMMEDIATE CAUSE (a) Acute myocardial infarction  |  |  |              |   |                                     |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Generalized advanced atherosclerosis   |  |  |              |   |                                     |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension + Diabetes mellitus   |  |  |              |   |                                     |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |              |   |                                     |  |  |  |  |   |  |
| ① Urinary infection   |  |  |              |   |                                     |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                     |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
|   |  |  |              |   |                                     |  |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |              | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |   |  |
|   |  |  |              | P.M. 19   |                                     |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                     | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |  |   |  |
|   |  |  |              |   |                                     |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/30, 1982, to 7/15, 1982, that (I) (we) lost saw the deceased alive on 7/15, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |              |   |                                     |  |  |  |  |   |  |
| 22b. SIGNATURE (TYPE OR PRINT)  |  |  |              | DEGREE  |                                     |  |  | 22c. DATE SIGNED   |  |   |  |
| B. HAKKI ADAM, MD   |  |  |              |   |                                     |  |  | 7/16/82  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |              | 22e. ADDRESS  |                                     |  |  |  |  |   |  |
| B. HAKKI ADAM, MD   |  |  |              | 6172 OXON HILL Rd.  |                                     |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  |  | 23b. DATE    |   | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION  |  | 23e. STATE  |  |
| Burial  |  |  | July 21, '82 |   | Md. VA                              |  |  | Cheltenham   |  | PG. Md.   |  |
| 24. FUNERAL DIRECTOR  |  |  |              | 25a. DATE REC'D. BY REGISTRAR   |                                     |  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| Thornton Funeral Home   |  |  |              | Pomomoy Maryland  |                                     |  |  | JUL 22 1982 Frances Jan Nathan   |  |   |  |

MEDICAL CERTIFICATION



Handwritten text, possibly a list or notes, located in the middle section of the page.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |   | 8 2 1 9 1 9 4  |  |
|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR  |  |   |   | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Jon Stephen Wilson   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>July 19, 1982                         |  | 2b. HOUR<br>3:05A M  |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH MONTH DAY YEAR<br>Jan. 15, 1957  | 6. AGE (IN YEARS, LAST BIRTHDAY)<br>25 YRS.                               | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, DC   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince Georges County MD          |  |  |
| 10. CITY OR TOWN OF DEATH<br>Laurel   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Greater Laurel Beltsville Hospital |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesman | 12b. KIND OF BUSINESS OR INDUSTRY<br>Shoe Store                                |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>A.A. Co.   | 13c. CITY OR TOWN<br>Laurel  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William S. Wilson  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Jennina Bassi               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No.  |  | 16b. SOCIAL SECURITY NO.<br>215-68-8765A  | 17. INFORMANT ADDRESS<br>Jennina Jenness same as #13                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY<br>5990 IMMEDIATE CAUSE (a) <u>Septicemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Urinary Tract Infection</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Urinary Diversion</u>                             |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br>Thomas A. MacLean   |  | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>7/19/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>THOMAS A. MAC LEAN   |  | 22e. ADDRESS<br>LAUREL MARYLAND 20707   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  | 23b. DATE<br>7/20/82   | 23c. NAME OF CEMETERY OR CREMATORY<br>Fort Lincoln Crematory Brentwood P.G.Co.Md.   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                     |  |
| 24. FUNERAL DIRECTOR<br>FLECK LAUREL FUNERAL HOME, INC.<br>7601 Sandy Spring Rd. Laurel, Md. 20707  |  | 25a. DATE RECEIVED BY REGISTRAR<br>JUL 20 1982  |   |  |  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item 11 per phone 8/4/82 dad  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE REGISTRAR

REG. NO. 72 19195

|   |                     |  |   |   |   |   |   |  |  |
|---|---------------------|--|---|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Samuel Theodore Woolger</b>  |                     |  |   |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input type="checkbox"/> 7 19 82                           |   | 2b. HOUR<br>8.35 PM  |  |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 27 24</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>57</b> YRS.        | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1 19</b>                                       |   | 2d. HOUR<br><b>1</b> PM  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges</b> MD.                               |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Laurel</b>  |                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br><b>Greater Laurel Beltsville Hosp.</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>accountant</b>              |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Md-Va. Milk Producers</b>        |  |
| 13a. STATE<br><b>Md</b>   |                     | 13b. COUNTY<br><b>Prince Georges</b>   |   | 13c. CITY OR TOWN<br><b>Laurel</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>8704 Dulwick Court</b>                         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel T. Woolger</b>  |                     |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Laura R. Lancaster</b>  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>  |                     |  | 16b. SOCIAL SECURITY NO.<br><b>193 14 9059</b>              |   | 17. INFORMANT ADDRESS<br><b>Muriel J. Woolger same as above</b>               |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>hx of aortic aneurysm Repair</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>High blood pressure</b>           |                     |  |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                     |  |   |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                     |  |   |   |   |   |   |  |  |
| ACTUAL SIGNATURE<br><b>Said A. Daeem</b>  |                     |  | TITLE (SPECIFY)<br><b>Deputy</b> M.D. MEDICAL EXAMINER      |   |   |   |   | DATE SIGNED<br><b>2-19-82</b>  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Said A. Daeem</b>  |                     |  | ADDRESS   |   |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                     | 23b. DATE<br><b>July 22, 1982</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Memorial</b>   |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville, Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Donaldson Funeral Home, Laurel, Md</b>   |                     |  | ADDRESS   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 28 1982</b>                           |   | 25b. REGISTRAR'S SIGNATURE<br><i>James J. Martin</i>                      |  |  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |   |  |   |  |   |                     | REG. NO. 8219196   |  |   |  |
|---|--|-------------------------|--|---|--|---|--|---|---------------------|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST M O O MIDDLE S. LAST Y I   |  |                         |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>7 14 1982<br>2b. HOUR<br>134                       |  |   |                     |  |  |   |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>KOREAN       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 15 07   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>75 YRS.   |  | 7. UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |                     | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>7 14 1982<br>2d. HOUR<br>1241      |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>KOREA  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>KOREA   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGES COUNTY MD.                |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>LANHAM   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Doctors' Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE  |                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME  |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                         |  |   |  |   |  |   |                     |  |  |   |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>P.G. CO. |  | 13c. CITY OR TOWN<br>LANHAM   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>6928 HEIDELBURG ROAD   |                     |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST (UNKNOWN) MIDDLE LAST  |  |                         |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST (UNKNOWN) MIDDLE LAST   |  |   |                     |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO   |  |                         |  | 16b. SOCIAL SECURITY NO.<br>NONE  |  | 17. INFORMANT<br>ADDRESS<br>CHONG U. YI (SON) SAME AS #13                                       |  |   |                     |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4408 IMMEDIATE CAUSE (a) Cardio respiratory arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. } (b) ASVD<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                         |  |   |  |   |  |   |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |                         |  |   |  |   |  |   |                     |  |  |   |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |                     |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                     |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                     |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |   |  |   |                     |  |  |   |  |
| ACTUAL SIGNATURE SAID A. DARE MD.   |  |                         |  |   |  | TITLE (SPECIFY)<br>Deputy   |  |   | DATE SIGNED 7-14-82 |  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) DR. SAID A. DARE, MD.   |  |                         |  |   |  | ADDRESS 5632 ANNAPOLIS RD. #4 GLADENSBURG, MD.  |  |   |                     |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |                         |  | 23b. DATE<br>JULY 16, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LAKEMONT MEMORIAL   |  |   |                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>DAVIDSONVILLE, PG. COUNTY MARYLAND |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>CHAMBERS FUNERAL HOME RIVERDALE, MD.  |  |                         |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 21 1982  |  | 25b. REGISTRAR'S NAME<br>[Signature]  |                     |  |  |   |  |

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CHICAGO  
UNIVERSITY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified for an examination.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Helen Swain Yoakam   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7 3 82   |   | 2b. HOUR<br>11 05 A M   |   |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 8 90  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 (91) YRS  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Iowa   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince Georges County, MD                               |   |
| 10. CITY OR TOWN OF DEATH<br>Forestville  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Regency Nursing Home |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home |
| 13a. STATE<br>Maryland  |   | 13b. COUNTY<br>Pr. Geo.   | 13c. CITY OR TOWN<br>Forestville  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George E. Swain   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Hedges   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A  |   | 17. INFORMANT<br>ADDRESS<br>1551 Woodruff Lane<br>Richard Yoakam<br>Bloomington, Indiana        |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 5990 URINARY TRACT INFECTION<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)  |   |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |   |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |   |   |
| 22b. SIGNATURE<br>William K. Furst  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |   | 22c. DATE SIGNED  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William K. Furst, M. D.  |   | 22e. ADDRESS<br>9401 Indian Head Highway, Oxon Hill, MD   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>July 6, 1982   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Christ Church Cemetery                                    |   |
| 23d. LOCATION<br>CITY OR TOWN<br>Clinton, Pr. Geo., MD  |   | 23e. DATE REC'D. BY REGISTRAR<br>JUL 6 1982   |   | 23f. REGISTRAR'S SIGNATURE<br>Pascas Jan Nathan   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Lee Funeral Home, Inc.<br>6638 Old Alexander Ferry Rd., Clinton, MD   |   |   |   |   |   |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR 415 ME (5))  
15M 7/77

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |   |   |                                   |  |
|--|--|---|--|---|---|---|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | 2a. DATE KNOWN OF DEATH  |   |   | 2b. HOUR  |                                   |  |
| FIRST MIDDLE LAST<br><b>Milliam (No Middle Initial) You</b>  |  |   | MONTH DAY YEAR<br><b>July 15 19 82</b>   |   |   | 2:12 PM   |                                   |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)  | IF UNDER 1 YR.  | IF UNDER 24 HRS.  | 7c. DATE PRONOUNCED DEAD  | 7d. HOUR                          |  |
| <b>Female</b>  | <b>Oriental</b>  | <b>June 3, 1890</b>   | <b>92</b> YRS.   | MONTHS DAYS HOURS MIN.  |   | <b>July 15 19 82</b>  | <b>2:12 PM</b>                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                                   |  |
| <b>Korea</b>   | <b>Korea</b>   |   |  |   |   | <b>Prince George's County MD.</b>   |                                   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |   |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| <b>Riverdale</b>   | <b>Leland Memorial Hospital</b>  |   |  | <b>Housewife</b>  |   |   | <b>Own Home</b>                   |  |
| 13a. STATE   |  |   | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |                                   |  |
| <b>Maryland</b>  |  |   | <b>P.G.</b>  | <b>Hyattsville</b>  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | <b>4020 Kennedy Street</b>  |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |   |   |   |                                   |  |
| <b>Unknown</b>   |  |   | <b>Unknown</b>   |   |   |   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT   |   | ADDRESS   |                                   |  |
| <b>No</b>  |  | <b>579-78-1085</b>  |  | <b>Mr. John J. Park</b>   |   | <b>Address Same as No# 13e.</b>   |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>0389 IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <u>Sepsis, acute cholecystitis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |   |   |                                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |  |   |   |   |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |   |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |                                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .      |  |   |  |   |   |   |                                   |  |
| ACTUAL SIGNATURE   |  | TITLE (SPECIFY)   |  |   |   | DATE SIGNED   |                                   |  |
| <b>Said A. Dace, M.D.</b>  |  | <b>Deputy</b>   |  |   |   | <b>7-15-82</b>  |                                   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  | ADDRESS   |  |   |   |   |                                   |  |
| <b>Said A. Dace, M.D.</b>  |  | <b>5632 Annapolis Rd. Suite #4-Blad. Md.</b>                |  |   |   |   |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |   |                                   |  |
| <b>Burial</b>  |  | <b>7-17-82</b>  | <b>Ft. Lincoln Cemetery</b>  |   | <b>Brentwood P.G. Maryland</b>                                      |   |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  |   | 25a. DATE REC'D. BY REGISTRAR  |   |   | REGISTRAR'S SIGNATURE   |                                   |  |
| <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>  |  |   | <b>JUL 19 1982</b>   |   |   | <b>Francis Gasch</b>  |                                   |  |

BP

DATE SIGNED 7-15-82

ADDRESS 5632 Annapolis Rd. Suite #4-Blad. Md.

F. Gasch's Sons F.H. P.A. Hyattsville, Md.

JUL 19 1982

Initial Initial

210

Prince George's County

X

Notes

Notes

Our Home

couple

L

Riverdale

4030 Kennedy Street

X

Hyattsville

P.G.

Hyattsville

Unknown

Unknown

Address same as

Box 150

Mr. John L. Park

278-78-1085

No

3833 Annapolis Rd. Suit 414 - Md. No.

John A. Green, M.D.

P.G. Hyattsville

Hyattsville

Ft. Lincoln Cemetery

7-17-82

Refined

E. George's Sons E.H. P.A. Hyattsville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |  |  |  |   |                            |
|--|--|--|---|---|--|--|--|--|---|----------------------------|
| 1. FOR STATE REGISTRAR   |  |  |   |   | REG. NO. 8 2 1 9 1 9 9   |  |  |  |   |                            |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ETHEL M ZEIBA</b>  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>07 16 82</b>  |  |  |  |   | 2b. HOUR<br><b>7:10 AM</b> |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>June 27, 1899</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS                                     |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 74 HRS. HOURS MIN.  |   |                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Rhode Island</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>PRINCE GEORGES</b> MD                     |  |  |   |                            |
| 10. CITY OR TOWN OF DEATH<br><b>CHEVERLY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PRINCE GEORGES GENERAL HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |   |                            |
| 13a. STATE<br><b>Maryland</b>  |  |  |   |   | 13b. COUNTY<br><b>P.G.</b>   |  | 13c. CITY OR TOWN<br><b>Laurel</b>                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Salas E. Fields</b>  |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Catherine Lee</b>   |  |  |  |   |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  |  |   |   | 16b. SOCIAL SECURITY NO<br><b>034-16-7306</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Ruthmary Lewis Kingman, Arizona</b>   |  |   |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>5715</b> IMMEDIATE CAUSE (a) <b>LIVER CIRRHOSIS WITH HEMORRHAGIC GASTRITIS</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>AND MASSIVE G.I BLEEDING</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |   |   |  |  |  |  |   |                            |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |                            |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |                            |
| 22a. I certify that (1) this hospital attended the deceased from <b>June 1982</b> to <b>July 16, 1982</b> , that (1) (we) last saw the deceased alive on <b>July 15, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated <b>(do) (did not) view the body after death.</b>   |  |  |   |   |  |  |  |  |   |                            |
| 22b. SIGNATURE <b>P. Schessler MD</b> DEGREE   |  |  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>July 16, 1982</b>   |   |                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>P. SCHSSLER MD</b>   |  |  |   |   | 22e. ADDRESS<br><b>7500 GREENWAY CRT DR. GREENBELT MD 20070</b>  |  |  |  |   |                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>July 20, 1982</b>                                   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Grove Street Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Putnam Windham Conn.</b> |  |   |                            |
| 24. FUNERAL DIRECTOR NAME<br><b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>   |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 20 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>James J. Martin</i>                   |  |   |                            |



P. Gasch's Sons P.O. Box 1, Uxattsville, Md.

Gravel July 20, 1982 Grove Street Cemetery Putnam  
Indiana Conn.

July 16, 1982

x

LIVE AIR-GOLF ALTIMETER/NO. 102121212  
WOMEN'S G.I. NEEDLE

No

034-16-7300

Mrs. Ruthmary Lewis Kington, Arizona

P.O. Box 2148

Catherine

Fields

E.

Salsa

Maryland

P.O.

Lance

x

P.O. Box 2724

Housewife

PRINCE GEORGE'S CB RAIL VERTICAL

Own Home

Rhode Island

P.R.I.

x

WINTER BEACHES

Female

White

June 27, 1982

82